S.R. 518 - by Schwartz: Extending welcome to Rabbi Samuel M. Stahl.

ADJOURNMENT

The President Pro Tempore announced the purpose of the Joint Session had been concluded and declared the Senate at 11:43 o'clock a.m. would stand adjourned until 10:30 o'clock a.m. Monday, April 18, 1977, in accordance with a motion previously adopted in the Senate.

APPENDIX

Sent to Governor

(April 14, 1977)

S.C.R. 86

FIFTY-SECOND DAY
(Monday, April 18, 1977)

The Senate met at 10:30 o'clock a.m., pursuant to adjournment, and was called to order by the President.

The roll was called and the following Senators were present: Adams, Aikin, Andujar, Braecklein, Brooks, Clower, Creighton, Doggett, Farabee, Hance, Harris, Jones of Harris, Jones of Taylor, Kothmann, Lombardino, Longoria, Mauzy, McKnight, Meier, Mengden, Moore, Ogg, Parker, Patman, Santiesteban, Schwartz, Sherman, Snelson, Traeger, Truan, Williams.

A quorum was announced present.

The Reverend Carl Siegenthaler, Director, Austin United Urban Council, Austin, Texas, offered the invocation as follows:

Let us bow as we acknowledge our ultimate accountability even beyond the people of Texas. O living, sovereign Creator and Lord, we know we need not invoke Your presence or activity. We know You have always been, are now and always will be engaged in the everyday life of Your people. Indeed, we join the Psalmist in singing:

Bless the Lord, oh my soul, and all that is within me, bless God's holy name;
Bless the Lord, oh my soul, and forget not all God's benefits:
Who forgives all our iniquities;
Who heals all our diseases;
Who redeems our lives from destruction;
Who crowns us with loving kindness and tender mercies;
Who satisfies our mouths with good things, so that our youth is renewed as the eagle's;

The Lord executes righteousness, and justice for those who are oppressed.
Bless the Lord, oh my soul, and all that is within me.

O sovereign Lord, help us, here, to participate with justice, and mercy, and humility in Your governance of Your people. Amen.

On motion of Senator Aikin and by unanimous consent, the reading of the Journal of the proceedings of Thursday, April 14, 1977, was dispensed with and the Journal was approved.

MESSAGE FROM THE HOUSE

House Chamber
April 18, 1977

Honorable William P. Hobby
President of the Senate

Sir: I am directed by the House to inform the Senate that the House has passed the following:

S.B. 625, Relating to the regulation of public grain warehouses; amending the Texas Grain Warehouse Act, as amended (Article 5577b, Vernon's Texas Civil Statutes).

S.C.R. 65, A memorial to Alejandra "MAMA" Jimenez.

The House has concurred in Senate amendments to House Bill No. 293 by a non-record vote.

H.B. 81, A bill to be entitled An Act relating to the registration and width requirements of certain vehicles used to load, transport, or spread fertilizer; and declaring an emergency.

H.B. 289, A bill to be entitled An Act relating to the appointment of an attorney ad litem in a proceeding for the appointment of a permanent guardian of an adult; amending the Texas Probate Code by adding Section 113A.

H.B. 444, A bill to be entitled An Act relating to the establishment and operation of a pilot multipurpose service center for displaced homemakers.

H.B. 743, A bill to be entitled An Act relating to the interest rate on delinquent taxes; amending the following provisions of Title 122A, Taxation—General, Revised Civil Statutes of Texas, 1925, as amended: Section (4) of Article 3.03; Section (10) of Article 4.03; Article 4.06; Section (1) of Article 5.03; Section (1) of Article 6.06; Article 9.18; Section (1) of Article 10.18; Section (1) of Article 10.68; Article 11.11; Article 12.14; Article 14.17; Article 18.03; Section (5) of Article 19.02; Section (H) of Article 20.05; Section (G) of Article 20.08; Section (1) of Article 21.04; and Article 23.07.

Respectfully submitted,
BETTY MURRAY, Chief Clerk
House of Representatives

REPORT OF STANDING COMMITTEE

Senator Creighton submitted the following report for the Committee on Economic Development:

S.B. 1179
S.B. 919
S.B. 936
S.B. 1101 (Amended)
S.B. 940
S.B. 888
S.B. 1100
C.S.S.B. 1156 (Read first time)

CO-AUTHORS OF SENATE BILL 1225

On motion of Senator Moore and by unanimous consent, Senators Schwartz and Brooks will be shown as Co-authors of **S.B. 1225.**

SENATE BILLS ON FIRST READING

By unanimous consent, the following bills were introduced, read first time and referred to the Committee indicated:

S.B. 1255 by Jones of Harris — Education
Relating to the authority of the Board of Regents of the University of Houston to levy and collect a fee for the operation, maintenance and improvement of university centers; amending Chapter 111, Subchapter C, Texas Education Code, by adding Section 111.42; and declaring an emergency.

S.B. 1256 by Hance — Economic Development
Relating to uninsured motorist insurance coverage; amending Chapter 202, Acts of the 60th Legislature, Regular Session, 1967 (Article 5.06-1, Insurance Code);

S.B. 1257 by Andujar — Human Resources
Relating to the minimum time required to complete a course of study in programs which prepare professional nurse practitioners; amending Section 1, Acts 1969, 61st Leg., p. 1566, Chapter 475 (Section 1, Article 4518, V.A.T.S.); and declaring an emergency.

S.B. 1258 by Mengden — Intergovernmental Relations
Relating to authorization of county and municipal law enforcement officers to assist other counties and municipalities in certain circumstances; amending Section 2, Chapter 81, Acts of the 61st Legislature, Regular Session, 1969 (Article 999b, Vernon's Texas Civil Statutes).

S.B. 1259 by Mengden, by request — State Affairs
Relating to the requirement that certain county officers and district attorneys disclose certain financial interests, activities, and gifts; providing penalties; amending Chapter 421, Acts of the 63rd Legislature, Regular Session, 1973 (Article 6252-9b, Vernon's Texas Civil Statutes), by adding Section 1A and amending Section 2(2).

VOTE BY WHICH SENATE REFUSED TO CONCUR IN HOUSE AMENDMENTS TO SENATE BILL 360 RECONSIDERED

On motion of Senator Moore and by unanimous consent, the Conference Committee on **S.B. 360** was discharged.

On motion of Senator Moore and by unanimous consent, the vote by which the Senate refused to concur in the House amendments to **S.B. 360** was reconsidered.

Question - Shall the Senate concur in the House amendments to **S.B. 360**?

Senator Moore moved to concur in the House amendments.

The motion prevailed by the following vote: Yeas 30, Nays 0.

Absent: Andujar.

SENATE BILL 459 WITH HOUSE AMENDMENT

Senator Lombardino called **S.B. 459** from the President's table for consideration of the House amendment to the bill.

The President laid the bill and the House amendment before the Senate.

Committee Amendment No. 1

Amend **S.B. 459** as follows:

Strike all language after the (.) period beginning on line 20, page 1 through line 7 on page 2.

The amendment was read.

Senator Lombardino moved to concur in the House amendment.

The motion prevailed.

CONFERENCE COMMITTEE REPORT ON HOUSE BILL 502

Senator Kothmann submitted the following Conference Committee Report:

Austin, Texas
April 13, 1977

Honorable William P. Hobby
President of the Senate

Honorable Bill Clayton
Speaker of the House of Representatives

Sir:

We, your Conference Committee, appointed to adjust the differences between the Senate and the House of Representatives on **H.B. 502** have met and had the

same under consideration, and beg to report it back with the recommendation that it do pass in the form and text hereto attached.

KOTHMANN
LOMBARDINO
TRAEGER
On the part of the Senate

BIRD
BOCK
LEWIS
HALL
GRANT
On the part of the House

The Conference Committee Report was read and was adopted by the following vote: Yeas 30, Nays 0.

Absent: Andujar.

COMMITTEE SUBSTITUTE HOUSE BILL 1048 ON SECOND READING

On motion of Senator Schwartz and by unanimous consent, the regular order of business was suspended to take up for consideration at this time on its second reading and passage to third reading:

C.S.H.B. 1048, Relating to health care liability insurance, certain providers of health care, and certain health care liability claims; providing penalties; adding Articles 5.15-1, 5.15-2, and 21.49-4 to and repealing Article 5.82 of the Insurance Code; amending Article 21.49-3 of the Insurance Code; amending Section 26.01(b), Business and Commerce Code; amending Section 1, Chapter 317, Acts of the 57th Legislature, Regular Session, 1961 (Article 1a, Vernon's Texas Civil Statutes); repealing Section 3, Chapter 331, Acts of the 64th Legislature, 1975.

The bill was read second time.

Senator Schwartz offered the following amendment to the bill:

Amend the committee substitute for **H.B. No.** 1048 by striking all below the enacting clause and substituting the following:

PART 1. MEDICAL LIABILITY
AND INSURANCE IMPROVEMENT
SUBCHAPTER A. GENERAL PROVISIONS

Section 1.01. SHORT TITLE. This part may be cited as the Medical Liability and Insurance Improvement Act of Texas.

Sec. 1.02. FINDINGS AND PURPOSES. (a) The Legislature of the State of Texas finds that:

(1) the number of health care liability claims (frequency) has increased since 1972 inordinately;

(2) the filing of legitimate health care liability claims in Texas is a contributing factor affecting medical professional liability rates;

(3) the amounts being paid out by insurers in judgments and settlements (severity) have likewise increased inordinately in the same short period of time;

(4) the effect of the above has caused a serious public problem in availability of and affordability of adequate medical professional liability insurance;

(5) the situation has created a medical malpractice insurance crisis in the State of Texas;

(6) this crisis has had a material adverse effect on the delivery of medical and health care in Texas, including significant reductions of availability of medical and health care services to the people of Texas and a likelihood of further reductions in the future;

(7) the crisis has had a substantial impact on the physicians and hospitals of Texas and the cost to physicians and hospitals for adequate medical malpractice insurance has dramatically risen in price, with cost impact on patients and the public;

(8) the direct cost of medical care to the patient and public of Texas has materially increased due to rising cost of malpractice insurance protection for physicians and hospitals in Texas;

(9) the crisis has increased the cost of medical care both directly through fees and indirectly through additional services provided for protection against future suits or claims; and defensive medicine has resulted in increasing cost to patients, private insurers, and the state and has contributed to the general inflation that has marked health care in recent years;

(10) satisfactory insurance coverage for adequate amounts of insurance in this area is often not available at any price;

(11) the combined effect of the defects in the medical, insurance, and legal systems has caused a serious public problem both with respect to the availability of coverage and to the high rates being charged by insurers for medical professional liability insurance to some physicians, health care providers, and hospitals;

(12) the adoption of certain modifications in the medical, insurance, and legal systems, the total effect of which is currently undetermined, may or may not have an effect on the rates charged by insurers for medical professional liability insurance;

(13) these facts have been verified by the Medical Professional Liability Study Commission, which was created by the 64th Legislature. For further amplification of these facts the legislature adopts the findings of the report of the commission.

(b) Because of the conditions stated in Subsection (a) of this section, it is the purpose of this Act to improve and modify the system by which health care liability claims are determined in order to:

(1) reduce excessive frequency and severity of health care liability claims through reasonable improvements and modifications in the Texas insurance, tort, and medical practice systems;

(2) decrease the cost of those claims and assure that awards are rationally unduly restrict a claimant's rights any
more than necessary to deal with the crisis;

(4) make available to physicians, hospitals, and other health care providers protection against potential liability through the insurance mechanism at reasonably affordable rates;

(5) make affordable medical and health care more accessible and available to the citizens of Texas;

(6) make certain modifications in the medical, insurance, and legal systems in order to determine whether or not there will be an effect on rates charged by insurers for medical professional liability insurance; and

(7) make certain modifications to the liability laws as they relate to health care liability claims only and with an intention of the legislature to not extend or apply such modifications of liability laws to any other area of the Texas legal system or tort law.

Sec. 1.03. DEFINITIONS. (a) In this part:

(1) "Court" means any federal or state court.

(2) "Health care" means any act or treatment performed or furnished, or which should have been performed or furnished, by any health care provider for, to, or on behalf of a patient during the patient's medical care, treatment, or confinement.

(3) "Health care provider" means any person, partnership, professional association, corporation, facility, or institution duly licensed or chartered by the State of Texas to provide health care as a registered nurse, hospital, dentist, podiatrist, pharmacist, or nursing home, or an officer, employee, or agent thereof acting in the course and scope of his employment.

(4) "Health care liability claim" means a cause of action against a health care provider or physician for treatment, lack of treatment, or other claimed departure from accepted standards of medical care or health care or safety which proximately results in injury to or death of the patient, whether the patient's claim or cause of action sounds in tort or contract.

(5) "Hospital" means a duly licensed public or private institution as defined in Chapter 223, Acts of the 56th Legislature, Regular Session, 1959, as amended (Article 4437f, Vernon's Texas Civil Statutes), or in Section 88, Chapter 243, Acts of the 55th Legislature, Regular Session, 1957 (Article 5547-88, Vernon's Texas Civil Statutes).

(6) "Medical care" means any act defined as practicing medicine in Article 4510, Revised Civil Statutes of Texas, 1925, as amended, performed or furnished, or which should have been performed, by one licensed to practice medicine in Texas for, to, or on behalf of a patient during the patient's care, treatment, or confinement.

(7) "Pharmacist" means one licensed under Chapter 107, Acts of the 41st Legislature, Regular Session, 1929, as amended (Article 4542a, Vernon's Texas Civil Statutes), who, for the purposes of this Act, performs those activities limited to the dispensing of prescription medicines which result in health care liability claims and does not include any other cause of action that may exist at common law against them, including but not limited to causes of action for the sale of mishandled or defective products.

(8) "Physician" means a person licensed to practice medicine in this state.

(9) "Representative" means the spouse, parent, guardian, trustee, authorized attorney, or other authorized legal agent of the patient or claimant.

(b) Any legal term or word of art used in this part, not otherwise defined in this part, shall have such meaning as is consistent with the common law.

SUBCHAPTER B. ADDITIONAL DISCIPLINARY POWERS

Sec. 2.01. DEFINITIONS. In this subchapter:

(1) "Board" means the Texas State Board of Medical Examiners.

(2) "Medical peer review committee" means a committee of a state or local professional medical society, the governing board of a licensed hospital in this state or of a medical staff of a licensed hospital, nursing home, or other health care facility, provided the committee or medical staff operates pursuant to written bylaws that have been approved by the policymaking body or the governing board of the society, hospital, nursing home, or other health care facility, or other organization of physicians formed pursuant to state or federal law and authorized to evaluate medical and health care services.

Sec. 2.02. REPORTING BY MEDICAL PEER REVIEW COMMITTEE OR PHYSICIAN. Any medical peer review committee in this state and any physician licensed to practice medicine or otherwise lawfully practicing medicine in this state may report relevant facts to the board relating to the acts of any physician in this state if, in the opinion of the medical peer review committee or the physician, they have knowledge relating to the physician that reasonably raises a question with respect to his or her competency.

Sec. 2.03. REPORTING BY PROFESSIONAL SOCIETY. A professional society in this state comprised primarily of physicians that takes formal disciplinary action against a member relating to professional ethics, medical incompetency, moral turpitude, or drug or alcohol abuse may report in writing to the board the name of the member, together with the pertinent information relating to the action.

Sec. 2.04. EFFECT OF FILING, INVESTIGATION, OR DISPOSITION BY BOARD. The filing of a report with the board pursuant to this article, investigation by the board, or any disposition by the board shall not, in and of itself, preclude any action by a hospital or other health care facility or professional society comprised primarily of physicians to suspend, restrict, or revoke the privileges or membership of the physician.

Sec. 2.05. HANDLING OF REPORT. On a determination by the board that a report submitted by a medical peer review committee is without merit, the report shall be expunged from the physician's or applicant's individual historical record in the board's office. A physician or applicant or his authorized representative is entitled on request to examine the physician's or applicant's medical peer review report submitted to the board under the provisions of this subchapter, and to place into the record a statement of reasonable length of the physician's or applicant's view with respect to any information existing in the report. The statement shall at all times accompany that part of the record in contention.

Sec. 2.06. CONFIDENTIALITY. (a) Reports, information, or records received and maintained by the board pursuant to this subchapter, including any material received or developed by the board during an investigation or hearing shall be strictly confidential and subject to the provisions of Subsection (c) of this section; however, the board may only disclose this confidential information:

(1) in a disciplinary hearing before the board or in a subsequent trial or appeal of a board action or order;

(2) to the physician licensing or disciplinary authorities of other jurisdictions, to a local, state, or national professional medical society, or to a medical peer review committee located inside or outside this state that is concerned with granting, limiting, or denying a physician hospital privileges;

(3) pursuant to an order of a court of competent jurisdiction; or

(4) to qualified personnel for bona fide research or educational purposes, if personally identifiable information relating to any person or physician is first deleted.

(b) Orders of the board relating to disciplinary action against a physician shall not be confidential.

(c) In no event shall confidential information received, maintained, or developed by the board, or disclosed by the board to others, pursuant to this article, be available for discovery or court subpoena, or introduced into evidence in a medical professional liability suit or other action for damages arising out of the provision of or failure to provide medical or health care services.

(d) A person found guilty of an unlawful disclosure of this confidential information possessed by the board shall be guilty of a Class A misdemeanor.

Sec. 2.07. IMMUNITY FROM CIVIL LIABILITY. A person reporting to or furnishing information to a medical peer review committee or the board, and a member, employee, or agent of the committee, who makes a report or other information available to the board pursuant to this subchapter, or who assists in the organization, investigation, or preparation of this information, or who assists the board in carrying out its duties or functions provided by law, shall be immune from civil liability.

Sec. 2.08. REPORTS AND DATA FROM INSURERS. (a) Every insurer providing medical professional liability insurance covering a physician or physicians in this state shall submit to the board the report or data described in Subsections (b)

and (c) of this section at the time prescribed. The report or data shall be provided with respect to a complaint filed against an insured in a health care screening panel or court, if the complaint seeks damages relating to the insured's conduct in providing or failing to provide medical or health care services, and with respect to settlement of a claim or lawsuit made on behalf of the insured. In the event a physician practicing medicine in this state does not carry or is not covered by medical professional liability insurance, or is insured by a nonadmitted carrier, the information required to be reported in Subsections (b) and (c) of this section shall be the responsibility of the physician.

(b) The following report or data shall be furnished to the board within 90 days after receipt by the insurer of the complaint from the insured:

(1) the name of the insured;

(2) the policy number;

(3) the policy limits;

(4) a copy of the complaint;

(5) a copy of the answer; and

(6) other pertinent data and information within the knowledge of the insurer as the board may require.

(c) The following report or data and information shall be furnished to the board within 90 days from a judgment, dismissal, or settlement of suit involving the insured, or settlement of any claim on behalf of the insured without the filing of a lawsuit:

(1) the date of a judgment, dismissal, or settlement;

(2) whether an appeal has been taken and by which party;

(3) the amount of the settlement or judgment against the insured; and

(4) other pertinent information within the knowledge of the insurer as the board may require.

(d) There shall be no liability on the part of and no cause of action of any nature shall arise against an insurer reporting under this section, or its agents or employees, or the board or its employees or representatives, for any action taken by them pursuant to this section.

(e) In the trial of a suit against a physician based on his conduct in providing or failing to provide medical or health care services, no report or data submitted to the board under this section nor the fact that the report or data has been submitted to the board may be offered in evidence or in any manner used in the trial of the case.

Sec. 2.09. REPORT OF FELONY CONVICTION. Within 30 days after the conviction of a person, known to be a physician, licensed or otherwise lawfully practicing in this state or applying to be so licensed to practice, of a felony under the laws of this state, the clerk of the court of record in which the conviction was entered shall prepare and forward to the board a certified true and correct abstract of record of the court governing the case. The abstract shall include the name and address of the physician or applicant, the nature of the offense committed, the sentence, and the judgment of the court. The board shall prepare the form of the abstract and shall distribute copies of it to all clerks of courts of record within this state with appropriate instructions for preparation and filing.

Sec. 2.10. REPORT OF BOARD ACTIONS. The board shall report within 30 days the restriction, suspension, or revocation of a physician's license or other disciplinary action by the board against a physician to the appropriate health facilities and hospitals, professional societies of physicians in this state, and any entity responsible for the administration of Medicare and Medicaid in this state.

Sec. 2.11. DENIAL OF LICENSE OR OTHER AUTHORIZATION AND DISCIPLINE OF PHYSICIAN. In addition to other powers previously granted, the board shall have authority to deny an application for a license or other

authorization to practice medicihe in this state and to discipline a physician licensed or otherwise lawfully practicing in this state, who, after a hearing, as provided in Article 4506, Revised Civil Statutes of Texas, 1925, as amended, has been adjudged by the board of:

(1) professional failure to practice medicine in the standard of care of a reasonable prudent physician; or

(2) being removed, suspended, or having disciplinary action taken by his or her peers in any professional medical association or society, whether the association or society is local, regional, state, or national in scope, or of being disciplined by a licensed hospital or the medical staff of a hospital, including removal, suspension, limitation of hospital privileges, or other disciplinary action, if that action in the opinion of the board was based on unprofessional conduct or professional incompetence which was likely to harm the public, provided that the board finds that the actions taken were appropriate and reasonably supported by evidence submitted to it.

Sec. 2.12. METHODS OF DISCIPLINE. If the board finds any person to have committed any of the acts set forth in Section 2.11 of this subchapter, it may enter an order imposing one or more of the following:

(1) deny the person's application for a license or other authorization to practice medicine;

(2) administer a public or private reprimand;

(3) suspend, limit, or restrict the person's license or other authorization to practice medicine, including limiting the practice of the person to or by the exclusion of one or more specified activities of medicine;

(4) revoke the person's license or other authorization to practice medicine;

(5) require the person to submit to care, counseling, or treatment of physicians designated by the board as a condition for initial, continued, or renewal of license or other authorization to practice medicine;

(6) require the person to participate in a program of education or counseling prescribed by the board; or

(7) require the person to practice under the direction of a physician designated by the board for a specified period of time.

Sec. 2.13. TEMPORARY SUSPENSION OF LICENSE. If the board determines from evidence or information presented to it that a person licensed to practice medicine in this state by his continuation in practice would constitute an immediate danger to the public, the board, on majority vote of the members, may temporarily suspend the license of that person without notice or hearing on the complaint, provided institution of proceedings for a hearing before the board is initiated simultaneously with the temporary suspension and provided that a hearing is held as soon as can be accomplished under Chapter 6, Title 71, Revised Civil Statutes of Texas, 1925, as amended, and the Administrative Procedure and Texas Register Act.

Sec. 2.14. APPEAL. A person against whom disciplinary action is taken pursuant to this subchapter shall have the right of judicial appeal as provided under Article 4506, Revised Civil Statutes of Texas, 1925, as amended, provided that the person may not be allowed to practice medicine or deliver health care services in violation of any disciplinary order or action of the board while the appeal is pending unless otherwise stayed by the district judge wherein the venue of the appeal lies.

Sec. 2.15. POWERS CUMULATIVE. The provisions of Subchapter B of this Act are in addition to other laws relating to medical disciplinary powers and procedures of the Texas State Board of Medical Examiners.

SUBCHAPTER C. DISTRICT REVIEW COMMITTEES

Sec. 3.01. DEFINITIONS. In this subchapter:

(1) "Board" means the Texas State Board of Medical Examiners.

(2) "Committee" means a district review committee.

(3) "District" means the district established in Section 3.02 of this subchapter.

Sec. 3.02. DISTRICTS. For the purposes of this subchapter, there shall be established a reasonable number of districts in Texas. The number of and geographic areas composed of various counties shall be designated by the board. Within six months after the effective date of this Act, the board, after a public hearing, shall designate the number of districts as in its opinion are needed and the counties to be included in the districts, shall notify the governor of the designation, and shall have the designation published in the Texas Register. After the initial designation of geographic areas in accordance with this section, the board, after a public hearing, may revise the number of districts and the composition of the various counties as it shall deem appropriate. In the event of change of the number or the composition of the various counties the board shall follow the same procedure as applies to the initial designations.

Sec. 3.03. CREATION OF COMMITTEES; COMPOSITION; APPOINTMENT OF MEMBERS; QUALIFICATIONS. A district review committee is created under the jurisdiction of the Texas State Board of Medical Examiners for each of the districts established in Section 3.02 of this subchapter. Each committee shall be composed of three persons appointed by the governor from among persons who have resided and practiced medicine in the district for more than three years before their appointment.

Sec. 3.04. TERM; MANNER OF APPOINTMENT. (a) Each member of each committee shall be appointed by the governor, after designation of the districts, for a term of six years, except the terms of the initial members shall be as provided in Subsection (c) of this section.

(b) Each member shall hold office as long as qualified and until the appointment and qualification of his successor or until six months have elapsed since the expiration of the term for which he was appointed, whichever first occurs.

(c) The initial members of each committee shall classify themselves by lot, so that one of them shall serve a term which expires January 15, 1978, one of them shall serve a term which expires January 15, 1980, and one of them shall serve a term which expires January 15, 1982.

Sec. 3.05. FILLING OF VACANCIES. Vacancies in the membership of a committee shall be filled by the governor by appointment for the unexpired term in the manner provided for making other appointments to a committee.

Sec. 3.06. PER DIEM AND EXPENSES. Each member of the committee shall receive the per diem and expenses provided for board members for actual duty or as provided by the board.

Sec. 3.07. RULES GOVERNING MEMBERS. Each member of a committee is subject to law and the rules of the board as if he were a member of the board, except members shall not be subject to the provisions of Chapter 421, Acts of the 63rd Legislature, Regular Session, 1973, as amended (Article 6252-9b, Vernon's Texas Civil Statutes).

Sec. 3.08. ADOPTION, AMENDMENT, OR REPEAL OF RULES. The board may adopt, amend, or repeal rules as may be reasonably necessary to carry into effect the provisions of this subchapter relating to:

(1) per diem and expenses of members;

(2) matters to be heard by or considered by the committees;

(3) the conduct of any hearings and the authority the board may delegate to the committees; and

(4) other matters relating to the committee's actions, duties, and responsibilities as may be reasonable.

Sec. 3.09. LIMITATION ON AUTHORITY. No committee may exercise final authority over the disposition of a complaint against a person licensed by the board or may issue a final order or rule, and the board must make final disposition of complaints against persons licensed by it and shall have the sole authority to issue final orders and rules.

SUBCHAPTER D. NOTICE AND NEGOTIATIONS

Sec. 4.01. NOTICE REQUIRED; FORM; PROCEDURE. At least 60 days before the filing of suit in any court of this state based upon a health care liability claim or a request for review of a health care liability claim by a health care screening panel, whichever occurs first, a person or his authorized agent asserting a health care liability claim shall give written notice by certified mail, return receipt requested, of the claim to the health care provider or physician against whom the claim is being made and shall request that the health care provider or physician enter into negotiations with the person to settle the claim.

Sec. 4.02. REPLY TO NOTICE; ATTEMPT TO SETTLE; MEDICAL RECORDS. The health care provider or physician shall make a written reply to the claimant by certified mail, return receipt requested, within 30 days after receipt of the written notice from the claimant and shall make a reasonable good-faith attempt to dispose of the claim by settlement. Further, the health care provider or physician shall also provide the claimant or his authorized agent with a complete and unaltered copy of the claimant's medical records relating to the health care in question within 10 days after written request by the claimant for such records. It is the intention of this section that all parties attempt to dispose of a health care liability claim without the necessity of review by a health care screening panel or the filing and pursuit of a lawsuit. Evidence of offers of settlement or attempts at settlement between the parties shall be inadmissible in any subsequent review by a health care screening panel or trial in accordance with existing law.

Sec. 4.03. PROOF OF COMPLIANCE. In the petition and answer, demand or request with or for a court, or review by a health care screening panel, the claimant and the health care provider or physician shall state that each has complied with this subchapter, that an opportunity to negotiate has been given to all parties as provided in this subchapter, and that all parties shall provide such evidence of the notice, response, and opportunity to negotiate as the judge of the court or chairman of the health care screening panel may require to determine if the provisions of this subchapter have been met.

Sec. 4.04. TOLLING STATUTE OF LIMITATIONS. Notice given as provided in this subchapter shall toll the applicable statute of limitations as to all potential parties for a period of 90 days following the giving of the notice provided for in this article; provided, further, that such notice shall toll the applicable statute of limitations as to all potential parties for a period of 30 days following the receipt of the decision of the health care screening panel as provided in Subchapter H of this part, if a request for such screening panel is given following the notice provided in this subchapter.

SUBCHAPTER E. AD DAMNUM CLAUSE

Sec. 5.01. PLEADINGS NOT TO STATE DAMAGE AMOUNT; SPECIAL EXCEPTION; EXCLUSION FROM SECTION. Pleadings in a suit based on a health care liability claim shall not specify an amount of money claimed as damages. The defendant may file a special exception to the pleadings on the ground the suit is not within the court's jurisdiction, in which event, the plaintiff shall inform the court and defendant in writing of the total dollar amount claimed. This section does not prevent a party from mentioning the total dollar amount claimed in examining prospective jurors on voir dire or in argument to the court or jury.

SUBCHAPTER F. INFORMED CONSENT

Sec. 6.01. DEFINITION. In this subchapter, "panel" means the Texas Medical Disclosure Panel.

Sec. 6.02. THEORY OF RECOVERY. In a suit against a physician or health care provider involving a health care liability claim that is based on the failure of the physician or health care provider to disclose or adequately to disclose the risks and hazards involved in the medical care or surgical procedure rendered by the physician or health care provider, the only theory on which recovery may be obtained is that of negligence in failing to disclose the risks or hazards that could have influenced a reasonable person in making a decision to give or withhold consent.

Sec. 6.03. TEXAS MEDICAL DISCLOSURE PANEL. (a) The Texas Medical Disclosure Panel is created to determine which risks and hazards related to medical care and surgical procedures must be disclosed by health care providers or physicians to their patients or persons authorized to consent for their patients and to establish the general form and substance of such disclosure.

(b) The panel is a division of the Texas Department of Health Resources and is under the supervision and subject to the rules and procedures of the Texas Department of Health Resources.

(c) The panel is composed of nine members, with three members licensed to practice law in this state and six members licensed to practice medicine in this state. Members of the panel shall be selected by the Director of Health Resources.

(d) Members of the panel serve for terms of two years, with their terms expiring on September 1 of each odd-numbered year. Vacancies on the panel are filled in the manner provided in Subsection (c) of this section for making the original selection and the person appointed to fill the vacancy serves for the unexpired term.

(e) Members of the panel are not entitled to compensation for their services, but each panelist is entitled to reimbursement of any necessary expense incurred in the performance of his duties on the panel including necessary travel expenses.

(f) Meetings of the panel shall be held at the call of the chairman or on petition of at least three members of the panel.

(g) At the first meeting of the panel after its members assume their positions, the panelists shall select one of the panel members to serve as chairman and one of the panel members to serve as vice-chairman. The chairman shall preside at meetings of the panel, and in his absence, the vice-chairman shall preside.

(h) Employees of the Texas Department of Health Resources shall serve as the staff for the panel.

Sec. 6.04. DUTIES OF PANEL. (a) To the extent feasible, the panel shall identify and make a thorough examination of all medical treatments and surgical procedures in which physicians and health care providers may be involved in order to determine which of those treatments and procedures do and do not require disclosure of the risks and hazards to the patient or person authorized to consent for the patient.

(b) The panel shall prepare separate lists of those medical treatments and surgical procedures that do and do not require disclosure and for those treatments and procedures that do require disclosure shall establish the degree of disclosure required and the form in which the disclosure will be made.

(c) Lists prepared under Subsection (b) of this section together with written explanations of the degree and form of disclosure shall be published in the Texas Register.

(d) At least annually, or at such other period the panel may determine from time to time, the panel will identify and examine any new medical treatments and surgical procedures that have been developed since its last determinations, shall assign them to the proper list, and shall establish the degree of disclosure required

and the form in which the disclosure will be made. These determinations shall be published in the Texas Register.

Sec. 6.05. DUTY OF PHYSICIAN OR HEALTH CARE PROVIDER. Before a patient or a person authorized to consent for a patient gives consent to any medical care or surgical procedure that appears on the panel's list requiring disclosure, the physician or health care provider shall disclose to the patient, or person authorized to consent for the patient, the risks and hazards involved in that kind of care or procedure. A physician or health care provider shall be considered to have complied with the requirements of this section if disclosure is made as provided in Section 6.06 of this subchapter.

Sec. 6.06. MANNER OF DISCLOSURE. Consent to medical care that appears on the panel's list requiring disclosure shall be considered effective under this subchapter if it is given in writing, signed by the patient or a person authorized to give the consent and by a competent witness, and if the written consent specifically states the risks and hazards that are involved in the medical care or surgical procedure in the form and to the degree required by the panel under Section 6.04 of this subchapter.

Sec. 6.07. EFFECT OF DISCLOSURE. (a) In a suit against a physician or health care provider involving a health care liability claim that is based on the negligent failure of the physician or health care provider to disclose or adequately to disclose the risks and hazards involved in the medical care or surgical procedure rendered by the physician or health care provider:

(1) both disclosure made as provided in Section 6.05 of this subchapter and failure to disclose based on inclusion of any medical care or surgical procedure on the panel's list for which disclosure is not required shall be admissible in evidence and shall create a rebuttable presumption that the requirements of Sections 6.05 and 6.06 of this subchapter have been complied with and this presumption shall be included in the charge to the jury; and

(2) failure to disclose the risks and hazards involved in any medical care or surgical procedure required to be disclosed under Sections 6.05 and 6.06 of this subchapter shall be admissible in evidence and shall create a rebuttable presumption of a negligent failure to conform to the duty of disclosure set forth in Sections 6.05 and 6.06 of this subchapter, and this presumption shall be included in the charge to the jury; but failure to disclose may be found not to be negligent if there was an emergency or if for some other reason it was not medically feasible to make a disclosure of the kind that would otherwise have been negligence.

(b) If medical care or surgical procedure is rendered with respect to which the panel has made no determination either way regarding a duty of disclosure, the physician or health care provider is under the duty otherwise imposed by law.

SUBCHAPTER G. RES IPSA LOQUITUR

Sec. 7.01. APPLICATION OF RES IPSA LOQUITUR. The common-law doctrine of res ipsa loquitur shall only apply to health care liability claims against health care providers or physicians in those cases to which it has been applied by the appellate courts of this state as of the effective date of this subchapter.

SUBCHAPTER H. HEALTH CARE SCREENING PANELS

Sec. 8.01. REVIEW OF HEALTH CARE LIABILITY CLAIMS. A health care liability claim shall be reviewed by a health care screening panel before it is filed in a court unless all parties agree in writing filed with the court in which the claim is filed to waive the institution of the panel.

Sec. 8.02. INITIATION OF PROCEEDINGS. (a) After notice and opportunity to negotiate is given to a health care provider or physician as provided by law, a person with a health care liability claim that has not been settled through negotiation or means other than court action and who wishes to pursue his claim unless waived by all parties under Section 8.01 of this subchapter, shall file with the

presiding judge of the administrative judicial district in which the claim arose a written request for a health care screening panel.

(b) The written request shall include:

(1) the name and address of the person making the request;

(2) the name and address of each health care provider or physician against whom a claim is being made;

(3) a general statement of the claim being made; and

(4) a request for the appointment of a panel.

(c) The written request for a panel and any information included in that request is confidential and, except as provided in this subchapter, is not subject to disclosure under Chapter 424, Acts of the 63rd Legislature, Regular Session, 1973, as amended (Article 6252-17a, Vernon's Texas Civil Statutes).

(d) Within five days after receiving the request for a panel, the presiding judge shall send by certified mail, return receipt requested, to each health care provider or physician named in the request, a copy of the request and notice of the convening of a panel.

Sec. 8.03. RELEASE AND WAIVER. (a) The claimant in a proceeding before a panel shall file with the panel within five days after the final appointment of the panel members a statement authorizing the panel to obtain access to all medical and hospital records and information pertaining to the matter giving rise to the health care liability claim and waiving any claim of privacy as to the contents of those records.

(b) The statement shall be signed by the claimant and properly notarized.

Sec. 8.04. SELECTION OF HEALTH CARE SCREENING PANEL. (a) The presiding judge of each administrative judicial district shall prepare a list of persons to serve on panels required to hear health care liability claims arising within their respective administrative judicial districts.

(b) The list shall include a sufficient number of persons to carry out efficiently the purposes of this subchapter. In preparing this list, the presiding judge may consult with and accept recommendations from state licensing boards and professional organizations.

(c) Each panel shall be composed of a district judge from the administrative judicial district in which the claim arose and three other persons, as provided in this subsection. If the claim is against a single physician or health care provider, panel members shall be licensed to provide the same type of medical care or health care as the physician or health care provider against whom the claim is made, and if a physician is the person against whom the claim is made, every effort shall be made to assure that physicians appointed to the panel are engaged in the same type of practice as the physician against whom the claim is made. If the claim is against an institutional health care provider, the panel shall consist of persons actively engaged as administrative officers of the same type of institutional health care provider as that against whom the claim is made. If the claim is against both single physicians and health care providers and institutional health care providers, two panel members shall be licensed to provide the same type of medical care and health care as the single physicians and health care providers against whom the claim is made and one panel member shall be actively engaged as an administrative officer of the same type of institutional health care provider as that against whom the claim is made. In all other claims involving multiple defendants, the panel shall be as proportionately representative of all defendants as possible.

(d) The district judge serving on the panel shall serve as the panel's presiding officer and shall have no vote.

(e) The plaintiff and the defendant shall each select a person from the list prepared under Subsection (a) of this section and those two persons shall select the third member of the panel.

(f) The district judge serving on the panel is prohibited from participating as a judge in any subsequent legal actions involving a claim heard before a panel of which he was a member.

(g) A person selected to be on a panel for a particular case may request to be relieved from service for good cause shown. To show good cause for relief from service, a proposed panelist must file an affidavit with the presiding judge of the administrative judicial district in whose district the claim is made. The affidavit shall state facts showing that service would constitute an unreasonable burden or undue hardship. The judge may excuse the panelist from service. A panelist to replace the excused panelist shall be selected in the manner provided for selection of the original panelist.

(h) Unless excused from service under Subsection (g) of this section, the failure or refusal of a panelist to serve may be punished as contempt.

(i) The administrative judge within 10 days after receipt of a request for the convening of a health care screening panel shall prepare the list for selection of the health care screening panel and institute the selection of the health care screening panel.

Sec. 8.05. NOTICE AND HEARING. (a) On convening the panel, the claimant shall be entitled to a hearing of his complaint before the panel.

(b) Within five days after the final appointment of all panel members, the chairman of the panel shall consult with other panel members and all parties shall establish a date, time, and place for the hearing to begin. Notice of the date, time, and place of the hearing shall be given by the chairman in writing to all panel members and parties. The notice may be given either by personal service or by certified mail, return receipt requested. A copy of the notice shall be filed with the presiding judge of the administrative judicial district in which the panel sits.

Sec. 8.06. DEPOSITIONS AND DISCOVERY. After notice is given of the hearing, the parties may take depositions and obtain discovery regarding the claim before the panel in the manner for civil suits before the district courts of this state. Discovery under this subchapter shall be completed within four months from the date of the request for a panel. On application to the district judge serving on the panel, sanctions shall be imposed for failure to comply with this section as provided for in the Texas Rules of Civil Procedure.

Sec. 8.07. RIGHTS AND PROCEDURES. (a) A health care liability claim before a panel shall be handled under procedural rules established collectively by the presiding judges of all the administrative judicial districts.

(b) The rules of evidence as applied in non-jury civil cases in the district courts of this state shall be followed.

(c) Witnesses may be called to testify by any of the parties, and all testimony shall be taken under oath.

(d) Copies of records, x-rays, and other documents and evidence may be submitted to the panel.

(e) Each party before the panel is entitled to be represented by counsel, to make opening and closing statements at the hearing, and to cross-examine all witnesses.

(f) No transcript or record of the proceeding is required, but a party, at his own expense, may have the proceedings transcribed or recorded.

Sec. 8.08. SUBPOENAS. The judge who is chairman of the panel, acting in his capacity as a district judge, shall, on application by a party to the proceeding, and may, on his own determination, issue a subpoena requiring a person to appear and be examined with reference to a matter within the scope of the proceeding and to produce books, records, or papers pertinent to the proceeding. Failure to comply with the subpoena may be punished as contempt.

Sec. 8.09. DECISION. (a) Within 10 days after the completion of a hearing, the panel shall file a written decision with the presiding judge of the administrative judicial district.

(b) The panel shall decide the issue of liability and shall state its conclusion in substantially the following language: "We find the defendant was actionably negligent in his care and/or treatment of the patient and we find for the claimant," or "We find the defendant was not actionably negligent in his care and/or treatment of the patient and we find for the defendant."

(c) The decision shall be signed by all members of the panel, but a member of the panel may file a written concurring or dissenting opinion.

(d) The presiding judge shall send by certified mail, return receipt requested, to each of the parties before the panel and their counsel, copies of the decision of the panel.

Sec. 8.10. ADMISSIBILITY OF PANEL DECISION IN COURT; PARTICIPATION OF PANELIST IN TRIAL. (a) The decision of the panel shall not be admitted into evidence in a subsequent suit involving the health care liability claim heard before the panel.

(b) Members of the panel may not be called by the parties as expert medical witnesses in a subsequent legal action involving a health care liability claim heard by a panel of which they were a member.

Sec. 8.11. LIABILITY OF PANELISTS. No member of a panel is liable in damages for libel, slander, or defamation of character of a party to the panel's proceedings for an action taken or a recommendation made by the panel member acting in his official capacity as a member of the panel.

Sec. 8.12. COMPENSATION OF PANEL MEMBERS. Each member of the panel other than the judge is entitled to receive not more than $50 a day for each day he is actually involved in the activities of the panel, but the total amount paid to a panel member may not be more than $250 for all work performed as a member of the panel. Each panel member, including the judge, is entitled to receive actual travel expenses incurred in attending hearings and meetings of the panel. Each side shall pay one-half of these expenses.

Sec. 8.13. TERMINATION OF PANEL AND TOLLING OF STATUTE OF LIMITATIONS. (a) Unless the time for completion is extended by written agreement of all the parties, a health care screening panel hearing under this subchapter shall be completed within six months from the date of the request for a panel whether or not a decision has been reached by the panel.

(b) A health care screening panel hearing on a health care liability claim tolls the applicable statute of limitations for filing suit until 30 days following receipt of the decision of the panel or 30 days following the termination of the panel as provided in Subsection (a) of this section.

Sec. 8.14. GOVERNING LAW. In a health care screening panel hearing under this subchapter, the provisions of this subchapter shall govern if a conflict exists between this subchapter and any other law.

Sec. 8.15. REPORTS. (a) The administrative judge shall transmit to the State Board of Insurance and the applicable licensing board of any defendant party a copy of the request for a panel within 10 days of filing. The reports shall be filed for informational purposes and the making or filing of a report shall not of itself be a ground for discipline.

(b) The administrative judge shall likewise transmit to the State Board of Insurance and the applicable licensing board of a defendant party a copy of the health care screening panel's decision within 10 days of filing. The State Board of Insurance and the applicable licensing board of any defendant may take such action based on the panel's decision as is appropriate under applicable law.

Sec. 8.16. DESIGNATION OF DISTRICT. For the purposes of this subchapter, Rockwall County shall be considered a part of the First Administrative Judicial District.

SUBCHAPTER I. BAD FAITH CAUSE OF ACTION

Sec. 9.01. SEPARATE CAUSE OF ACTION FOR BAD FAITH. With respect to a health care liability claim actually filed, a cause of action based on bad faith may be filed and litigated in a separate lawsuit.

Sec. 9.02. DEFINITION. As used in this subchapter, "bad faith" means to file and maintain a claim with reckless disregard as to whether or not reasonable grounds exist for asserting the claim.

Sec. 9.03. NOTICE OF BAD FAITH CLAIM. At least 60 days before the filing of a suit based on bad faith in any court of this state, a person or his authorized agent asserting a bad faith cause of action shall give written notice by certified mail, return receipt requested, of the claim, to the defendant or his attorney against whom the claim is being made.

Sec. 9.04. PERSONS AGAINST WHOM CLAIMS MAY BE MADE; DAMAGE LIMITS. The right of action created in this subchapter shall lie against any claimant or defendant or claimant's or defendant's attorney, or both, who file a health care liability claim in bad faith, or file a claim under this article in bad faith, and the measure of damages with respect thereto shall be limited to $100,000 for compensatory and exemplary damages, as applicable.

Sec. 9.05. EFFECTIVE DATE. This subchapter will take effect if and only if the State Bar of Texas fails to certify to the Supreme Court of Texas by January 31, 1979, that it has adopted rules for appropriate disciplinary measures against an attorney who has been determined to have filed a claim in bad faith.

SUBCHAPTER J. ADVANCE PAYMENTS

Sec. 10.01. ADVANCE PAYMENTS NOT ADMISSION OF LIABILITY. In an action brought to recover damages based on a health care liability claim, no advance payment made on that claim by the defendant health care provider or physician, or the professional liability insurer, to or for the claimant, or any other person, shall be construed as an admission of liability by the health care provider or physician or any person for any injuries or damages suffered by the claimant or anyone else.

Sec. 10.02. ADMISSIBILITY OF ADVANCE PAYMENTS. Except as provided in this subchapter, evidence of an advance payment shall not be admissible during the trial of an action based on a health care liability claim at any stage of the proceedings, unless and until there is a final award in favor of the claimant, in which event the trial judge shall reduce the award to the claimant to the extent of the advance payment.

Sec. 10.03. ADJUSTMENTS FOR ADVANCE PAYMENTS. The advance payment shall inure to the exclusive benefit of the defendant or his or its carrier making the advance payment, and in the event the advance payment exceeds the pro rata liability of the defendant or the carrier making the payment, the trial judge shall order any adjustment necessary to equalize the amount which each defendant is obligated to pay under this subchapter, exclusive of costs.

Sec. 10.04. CERTAIN ADVANCE PAYMENTS EXEMPT FROM REPAYMENT. In no case shall an advance payment in excess of an award be repayable by the person receiving it.

SUBCHAPTER K. STATUTE OF LIMITATIONS

Sec. 11.01. LIMITATIONS ON HEALTH CARE LIABILITY CLAIMS Notwithstanding any other law, no health care liability claim may be commenced unless the action is filed within two years from the occurrence of the breach or tort or from the date the medical or health care treatment that is the subject of the claim or the hospitalization for which the claim is made is completed; provided that

minors under the age of 12 years shall have until their 14th birthday in which to file, or have filed on their behalf, the claim. Except as herein provided, this subchapter applies to all persons regardless of minority or other legal disability.

Sec. 11.02. CAUSES OF ACTION COVERED BY OTHER LAW. Causes of action accruing between the effective date of this Act and the effective date of Article 5.82, Insurance Code, shall be filed pursuant to Section 4 of Article 5.82.

SUBCHAPTER L. LIABILITY LIMITS

Sec. 12.01. DEFINITION. In this subchapter, "consumer price index" means the index published by the Bureau of Labor Statistics of the United States Department of Labor that measures the average change in prices of goods and services purchased by urban wage earners and clerical workers' families and single workers living alone.

Sec. 12.02. LIMIT ON CIVIL LIABILITY. (a) In an action on a health care liability claim where final judgment is rendered against a physician or health care provider, the limit of civil liability for damages of the physician or health care provider shall be limited to an amount not to exceed $500,000. This section shall not limit the liability where facts exist that would enable a party to invoke the common law theory of recovery commonly known in Texas as the "Stowers's Doctrine."

(b) Subsection (a) of this section does not apply to the amount of damages awarded on a health care liability claim for the expenses of necessary medical, hospital, and custodial care received before judgment or required in the future for treatment of the injury.

Sec. 12.03. ADJUSTMENT OF LIABILITY LIMITS. When there is an increase in the consumer price index over the amount of that index on the effective date of this subchapter, the amount of damages awarded shall not exceed $500,000 plus the result of $500,000 multiplied by the percentage increase in the consumer price index between the effective date of this article and the time at which the damages are awarded.

Sec. 12.04. ALTERNATIVE LIABILITY. In the event that Section 12.02 of this subchapter is stricken from this subchapter by a method other than through legislative means, the following shall become effective:

In an action for injury based on a health care liability claim where final judgment is rendered against a physician or health care provider, the injured plaintiff shall be entitled to recover noneconomic losses to compensate for pain and suffering, provided, however, that in the action, the total amount of all such damages shall not exceed $150,000, except in the case of disfigurement.

Sec. 12.05. SUBCHAPTER'S APPLICATION PREVAILS OVER CERTAIN OTHER LAWS. The provisions of this subchapter shall apply notwithstanding the provisions contained in Article 4671, Revised Civil Statutes of Texas, 1925, as amended, and the provisions of Article 5525, Revised Civil Statutes of Texas, 1925, as amended.

SUBCHAPTER M. MISCELLANEOUS PROVISIONS

Sec. 13.01. EXCEPTION FROM CERTAIN LAWS. (a) Notwithstanding any other law, no provisions of Sections 17.41-17.63, Business & Commerce Code, shall apply to physicians or health care providers as defined in Section 1.03(3) of this Act, with respect to claims for damages for personal injury or death resulting, or alleged to have resulted, from negligence on the part of any physician or health care provider.

(b) This section shall not apply to pharmacists.

PART 2. ORAL WARRANTY; EMERGENCY CARE

Sec. 21.01. Subsection (b), Section 26.01, Business & Commerce Code, is amended to read as follows:

"(b) Subsection (a) of this section applies to:

"(1) a promise by an executor or administrator to answer out of his own estate for any debt or damage due from his testator or intestate;

"(2) a promise by one person to answer for the debt, default, or miscarriage of another person;

"(3) an agreement made on consideration of marriage;

"(4) a contract for the sale of real estate;

"(5) a lease of real estate for a term longer than one year;

"(6) an agreement which is not to be performed within one year from the date of making the agreement; [~~and~~]

"(7) a promise or agreement to pay a commission for the sale or purchase of:

"(A) an oil or gas mining lease;

"(B) an oil or gas royalty;

"(C) minerals; or

"(D) a mineral interest; and

"(8) an agreement, promise, contract, or warranty of cure relating to medical care or results thereof made by a physician or health care provider as defined in Section 1.03, Medical Liability and Insurance Improvement Act of Texas. This section shall not apply to pharmacists."

Sec. 21.02. Section 1, Chapter 317, Acts of the 57th Legislature, Regular Session, 1961 (Article 1a, Vernon's Texas Civil Statutes), is amended to read as follows:

"Section 1. EMERGENCY CARE; RELIEF FROM LIABILITY FOR CIVIL DAMAGES. No person shall be liable in civil damages who administers emergency care in good faith at the scene of an emergency or in a hospital for acts performed during the emergency unless such acts are wilfully or wantonly negligent; provided that nothing herein shall apply to the administering of such care where the same is rendered for remuneration or with the expectation of remuneration or is rendered by any person or agent of a principal who was at the scene of the accident or emergency because he or his principal was soliciting business or seeking to perform some services for remuneration; and further provided that this Section shall not apply to a person who regularly administers care in a hospital emergency room or to an admitting physician, or to a treating physician associated by the admitting physician, of the patient bringing a health care liability claim."

PART 3. INSURANCE

Sec. 22.01. Subchapter B, Chapter 5, Insurance Code, is amended by adding Article 5.15-1 to read as follows:

"Article 5.15-1. PROFESSIONAL LIABILITY INSURANCE FOR PHYSICIANS AND HEALTH CARE PROVIDERS

"Section 1. SCOPE OF ARTICLE. This article shall apply to the making and use of insurance rates by every insurer licensed to write or engaged in writing professional liability insurance for any physician or any health care provider including rating organizations, acting on behalf of insurers.

"Section 2. DEFINITIONS. In this article:

"(1) 'Physician' means a person licensed to practice medicine in this state.

"(2) 'Health care provider' means any person, partnership, professional association, corporation, facility, or institution licensed or chartered by the State of Texas to provide health care as a registered nurse, hospital, dentist, podiatrist, chiropractor, optometrist, or not-for-profit nursing home, or an officer, employee, or agent of any of them acting in the course and scope of his employment.

"(3) 'Hospital' means a licensed public or private institution as defined in Chapter 223, Acts of the 56th Legislature, Regular Session, 1959, as amended (Article 4437f, Vernon's Texas Civil Statutes), or in Section 88, Chapter 243, Acts of the 55th Legislature, Regular Session, 1957 (Article 5547-88, Vernon's Texas Civil Statutes).

"Section 3. RATE STANDARDS. Rates shall be made in accordance with the following provisions:

"(a) Consideration shall be given to past and prospective loss and expense experience inside this state, unless the State Board of Insurance shall find that the group or risk to be insured is not of sufficient size to be deemed credible, in which event, past and prospective loss and expense experience outside this state shall also be considered, to a reasonable margin for underwriting profit and contingencies, to investment income, to dividends or savings allowed or returned by insurers to their policyholders or members.

"(b) For the establishment of rates, risks may be grouped by classifications, by rating schedules, or by any other reasonable methods. Classification rates may be modified to produce rates for individual risks in accordance with rating plans which establish standards for measuring variations in hazards or expense provisions, or both. Those standards may measure any difference among risks that can be demonstrated to have a probable effect upon losses or expenses.

"(c) Rates shall be reasonable and shall not be excessive or inadequate, as defined in this subsection, nor shall they be unfairly discriminatory. No rate shall be held to be excessive unless the rate is unreasonably high for the insurance coverage provided and a reasonable degree of competition does not exist in the area with respect to the classification to which the rate is applicable. No rate shall be held to be inadequate unless the rate is unreasonably low for the insurance coverage provided and is insufficient to sustain projected losses and expenses; or unless the rate is unreasonably low for the insurance coverage provided and the use of the rate has or, if continued, will have the effect of destroying competition or creating a monopoly.

"Section 4. FILING OF RATES. (a) The provisions of Article 5.15, Insurance Code, shall apply to the filing of rates and rating information required under this article.

"(b) Nothing contained in this article or other provisions of this subchapter concerning the regulation of rates, rating plans, and rating classifications shall, as applies to the writing of professional liability insurance for health care providers and physicians, give the board the power to prescribe uniform or absolute rates; nor shall anything therein be construed as preventing the filing of different rates for risks in a given classification or modified rates for individual risks made in accordance with rating plans, as filed by different insurers or organizations authorized to file such rates. As used in this subsection, 'absolute rates' means rates, rating classifications, or rating plans filed by an insurer or authorized rating organization in accordance with this subchapter and the rates, rating classifications, or rating plans so filed are required to be used, to the exclusion of all others, by each insurer lawfully engaged in writing policies.

"(c) The State Board of Insurance shall prescribe standardized policy forms for occurrence, claims-made and claims-paid policies of professional liability insurance covering health care providers and physicians, and no insurer may use any other forms in writing professional liability insurance for health care providers and physicians without the prior approval of the State Board of Insurance. However, an insurer writing professional liability insurance for health care providers and physicians may use any form of endorsement if the endorsement is first submitted to and approved by the board.

"Section 5. REPORTING OF CLAIMS AND CLAIMS INFORMATION. Each insurer who issues policies of professional liability insurance covering physicians and health care providers shall file annually with the State Board of Insurance a report of all claims and amount of claims, amounts of claims reserves, investment income of the company derived from medical professional liability premiums, information relating to amounts of judgments and

settlements paid on claims, and other information required by the board. The board may formulate and promulgate a form on which this information shall be reported. The form shall be so devised as to require the information to be reported in an accurate manner, reasonably calculated to facilitate interpretation and to protect the confidentiality of the health care provider or physician.

"Section 6. ANNUAL PREMIUMS. Policies of professional liability insurance under this article shall be written on not less than an annual premium basis.

"Section 7. NOTICE OF CANCELLATION OR NONRENEWAL. An insurer who issues a policy of professional liability insurance covered by this article shall give at least 90 days' written notice to an insured if premiums on the insurance are to be increased or the policy is to be cancelled or is not to be renewed other than for nonpayment of premiums or because the insured is no longer licensed. If the premiums are to be increased, the notice shall state the amount of the increase, and if the policy is to be cancelled or is not to be renewed, the insurer shall state in the notice the reason for cancellation or nonrenewal. Notice of cancellation under this section may only be given within the first 90 days from the effective date of the policy.

"Section 8. PUNITIVE DAMAGES UNDER MEDICAL PROFESSIONAL LIABILITY INSURANCE. No policy of medical professional liability insurance issued to or renewed for a health care provider or physician in this state may include coverage for punitive damages that may be assessed against the health care provider or physician.

"Section 9. CLAIM SURCHARGES. A claim surcharge assessed by an insurer against a health care provider or physician under a professional liability insurance policy may be based only on claims actually paid by an insurer as a result of a settlement or an adverse judgment or an adverse decision of a court."

Sec. 22.02. Chapter 5, Insurance Code, is amended by adding Article 5.15-2, to read as follows:

"Article 5.15-2. ACCIDENT PREVENTION SERVICES

"(a) Any insurer desiring to write professional liability insurance for hospitals in Texas shall maintain or provide accident prevention facilities as a prerequisite for a license to write such insurance. Such facilities shall be adequate to furnish accident prevention services required by the nature of its policyholder's operations and shall include surveys, recommendations, training programs, consultations, analyses of accident causes and hospital risk control management, to implement the program of accident prevention services. Each field safety representative shall be either a college graduate who shall have a bachelor's degree in science or engineering, a registered professional engineer, a certified safety professional, or an individual who shall have completed a course of training in accident prevention services approved by the State Board of Insurance.

"(b) The insurer shall render accident prevention services to its policyholders reasonably commensurate with the risks and exposures and experience of the subscriber's business. To provide such facilities, the insurer may employ qualified personnel, retain qualified independent contractors, contract with the policyholder to provide qualified accident prevention personnel and services, or use a combination of the methods enumerated in this subsection. Such personnel shall have the qualification required for field safety representatives as provided in Subsection (a) of this article.

"(c) If the Commissioner of Insurance shall determine that reasonable accident prevention services are not being maintained or provided by the insurer or are not being used by the insurer in a reasonable manner to prevent injury to patients of its policyholders, the fact shall be reported to the State Board of Insurance, and the board shall order a hearing to determine if the insurer is not in

compliance with this article. If it is determined that the insurer is not in compliance, its authority to write professional liability insurance for hospitals in Texas shall be revoked.

"(d) The State Board of Insurance may promulgate reasonable rules and regulations for the enforcement of this article after holding a public hearing on the proposed rules and regulations.

"(e) In this article, 'hospital' means a licensed public or private institution as defined in Chapter 223, Acts of the 56th Legislature, Regular Session, 1959, as amended (Article 4437f, Vernon's Texas Civil Statutes), or in Section 88, Chapter 243, Acts of the 55th Legislature, Regular Session, 1957 (Article 5547-88, Vernon's Texas Civil Statutes).

"(f) The provisions of this section shall become effective on January 1, 1978."

Sec. 22.03. Section 2, Article 21.49-3, Insurance Code, is amended to add Subdivisions (5) and (6) to read as follows:

"(5) 'Physician' means a person licensed to practice medicine in this state.

"(6) 'Health care provider' means any person, partnership, professional association, corporation, facility, or institution duly licensed or chartered by the State of Texas to provide health care as defined in Section 1.03(2), Medical Liability Insurance Improvement Act of Texas, as a registered nurse, hospital, dentist, podiatrist, pharmacist, chiropractor, optometrist, or nursing home, or a radiation therapy center that is independent of any other medical treatment facility and which is licensed by the Texas State Radiation Control Agency pursuant to the provisions of Chapter 72, Acts of the 57th Legislature, Regular Session, 1961, as amended (Article 4590f, Vernon's Texas Civil Statutes), and which is in compliance with the regulations promulgated by the Texas State Radiation Control Agency, a blood bank that is a nonprofit corporation chartered to operate a blood bank and which is accredited by the American Association of Blood Banks, or a nonprofit corporation which is organized for the delivery of health care to the public and which is certified under Article 4509a, Revised Civil Statutes of Texas, 1925, or an officer, employee, or agent of any of them acting in the course and scope of his employment."

Sec. 22.04. Subdivision (1), Section 2, Article 21.49-3, Insurance Code, is amended to read as follows:

"(1) 'Medical liability insurance' means primary and excess insurance coverage against the legal liability of the insured and against loss, damage, or expense incident to a claim arising out of the death or injury of any person as the result of negligence in rendering or the failure to render professional service by a health care provider or physician who is in one of the categories eligible for coverage by the association ~~[one licensed to practice medicine or podiatry or certified to administer anesthesia in this state or any hospital licensed under the Texas Hospital Licensing Law, as amended (Article 4437f, Vernon's Texas Civil Statutes)]~~."

Sec. 22.05. Subsections (a) and (b), Section 3, Article 21.49-3, Insurance Code, are amended to read as follows:

"(a) A joint underwriting association is hereby created, consisting of all insurers authorized to write and engaged in writing, within this state, on a direct basis, automobile liability and liability other than auto insurance on or after January 1, 1975, as provided in the Insurance Code, specifically including and applicable to Lloyds and reciprocal or interinsurance exchanges, but excluding farm mutual insurance companies as authorized by Chapter 16 of this code, and county mutual insurance companies as authorized by Chapter 17 of this code. Every such insurer shall be a member of the association and shall remain a member as a condition of its authority to continue to transact such kind of insurance in this state. The purpose of the association shall be to provide medical liability insurance on a self-supporting basis. The association shall not be a licensed insurer within the meaning of Article 1.14-2, Insurance Code.

"(b) The association shall, pursuant to the provisions of this article and the plan of operation with respect to medical liability insurance, have the power on behalf of its members:

"(1) to issue, or to cause to be issued, policies of insurance to applicants, including primary, excess, and incidental coverages and subject to limits as specified in the plan of operation; provided that no individual or organization may be insured by policies issued by the association for an amount exceeding a total of $500,000 per occurrence and $1 million aggregate per annum or, if there is validly established by the Legislature of the State of Texas a maximum amount directly recoverable from a physician or health care provider, for a health care liability claim as defined in the Medical Liability and Insurance Improvement Act of Texas, then such maximum amount per occurrence and $1 million aggregate per annum [~~$200,000~~];

"(2) to underwrite such insurance and to adjust and pay losses with respect thereto, or to appoint service companies to perform those functions;

"(3) to either or both accept and refuse the assumption of [~~assume~~] reinsurance from its members; and

"(4) to cede and purchase reinsurance."

Sec. 22.06. Subdivisions (2) and (3), Subsection (c), Section 3, Article 21.49-3, Insurance Code, are amended to read as follows:

"(2) The plan of operation shall provide for economic, fair, and nondiscriminatory administration and for the prompt and efficient provision of medical liability insurance, and shall contain other provisions including, but not limited to, preliminary assessment of all members for initial expenses necessary to commence operations, establishment of necessary facilities, management of the association, assessment of members and assessment of policyholders to defray losses and expenses, administration of the policyholder's stabilization reserve fund, commission arrangements, reasonable and objective underwriting standards, acceptance, assumption, and cession of reinsurance, appointment of servicing carriers, and procedures for determining amounts of insurance to be provided by the association.

"(3) The plan of operation shall provide that any balance remaining in the funds of the association at the close of its fiscal year, meaning its then excess of revenue over expenditures [~~profit achieved~~] after reimbursement of members' contributions in accordance with Section 4(b)(5) of this article by the association shall be added to the reserves of the association."

Sec. 22.07. Article 21.49-3, Insurance Code, is amended by adding Section 3A to read as follows:

"Section 3A. ELIGIBILITY FOR COVERAGE. The board shall establish by order the categories of physicians and health care providers who are eligible to obtain coverage from the association and may, from time to time, revise its order to include or exclude from eligibility particular categories of such physicians and health care providers."

Sec. 22.08. Section 4, Article 21.49-3, Insurance Code, is amended to read as follows:

"Section 4. (a)(1) Any health care provider or physician included in one of the categories of health care providers eligible for coverage by the association [~~licensed physician, licensed podiatrist, or hospital or certified anesthetist~~] shall, on or after the effective date of the plan of operation, be entitled to apply to the association for such coverage. Such application may be made on behalf of an applicant by an agent authorized pursuant to Article 21.14 of this code.

"(2) If the association determines that the applicant meets the underwriting standards of the association as prescribed in the plan of operation and there is no unpaid, uncontested premium, policyholder stabilization reserve fund charge, or assessment due from the applicant for prior insurance (as shown by the insured

having failed to pay or make written objection to such [~~premium~~] charges within 30 days after billing) then the association, upon receipt of the premium and the policyholder stabilization reserve fund charge, or such portion thereof as is prescribed in the plan of operation, shall cause to be issued a policy of medical liability insurance for a term of one year.

"(b)(1) The rates, rating plans, rating rules, rating classifications, territories, and policy forms applicable to the insurance written by the association and statistics relating thereto shall be subject to Subchapter B of Chapter 5 of the Insurance Code, as amended, giving due consideration to the past and prospective loss and expense experience for medical professional liability insurance within and without this state of all of the member companies of the association, trends in the frequency and severity of losses, the investment income of the association, and such other information as the board may require; provided, that if any article of the above subchapter is in conflict with any provision of this Act, this Act shall prevail.

"(2) Within such time as the board shall direct, the association shall submit, for the approval of the board pursuant to Article 5.15 of the Insurance Code, an initial filing, in proper form, of policy forms, classifications, rates, rating plans, and rating rules applicable to medical liability insurance to be written by the association.

"(3) Any deficit sustained by the association in any one year shall be recouped, pursuant to the plan of operation and the rating plan then in effect, by one or more of the following procedures in this sequence:

"First, a contribution from the policyholder's stabilization reserve fund until the same is exhausted;

"Second, [~~(A)~~] an assessment upon the policyholders pursuant to Section 5(a) of this article;

[~~(B) a rate increase applicable prospectively;~~]

"Third, an assessment upon the members pursuant to Section 5(b) of this article. To the extent a member has paid one or more assessments and has not received reimbursement from the association in accordance with Subdivision (5) of this subsection, [~~(C)~~] a credit against premium taxes under Article 7064, Revised Civil Statutes of Texas, 1925, as amended, shall be allowed. The tax credit shall be allowed at a rate of 20 percent per year for five successive years following the year in which said deficit was sustained and at the option of the insurer may be taken over an additional number of years.

"(4) After the initial year of operation, rates, rating plans, and rating rules, and any provision for recoupment should be based upon the association's loss and expense experience, together with such other information based upon such experience as the board may deem appropriate. The resultant premium rates shall be on an actuarially sound basis and shall be calculated to be self-supporting.

"(5) In the event that sufficient funds are not available for the sound financial operation of the association, in addition to assessments paid pursuant to the plan of operation in accordance with Section 3 [~~(3)~~] (c)(2) of this [~~the~~] article and contributions from the policyholder's stabilization reserve fund, all members shall, on a basis authorized by the board, as long as the board deems it necessary, contribute to the financial requirements of the association in the manner provided for in Section 5. Any assessment or contribution shall be reimbursed to the members with interest at a rate to be approved by the board. Pending recoupment or reimbursement of assessments or contributions paid to the association by a member, the unrepaid balance of such assessments and contributions may be reflected in the books and records of the insurer as an admitted asset of the insurer for all purposes, including exhibition in annual statements pursuant to Article 6.12 of this code.

"(c) Excess insurance coverage written for a health care provider or a physician by the association under this article shall be written on a following form basis to the primary insurance coverage of that health care provider."

Sec. 22.09. Article 21.49-3, Insurance Code, is amended by adding Section 4A to read as follows:

"Section 4A. POLICYHOLDER'S STABILIZATION RESERVE FUND. There is hereby created a policyholder's stabilization reserve fund which shall be administered as provided herein and in the plan of operation of the association. Each policyholder shall pay annually into the stabilization reserve fund a charge, the amount of which shall be established annually by advisory directors chosen by health care providers and physicians eligible for insurance in the association in accordance with the plan of operation. The charge shall be in proportion to each premium payment due for liability insurance through the association. Such charge shall be separately stated in the policy, but shall not constitute a part of premiums or be subject to premium taxation, servicing fees, acquisition costs, or any other such charges. The policyholder's stabilization reserve fund shall be collected and administered by the association and shall be treated as a liability of the association along with and in the same manner as premium and loss reserves. The fund shall be valued annually by the board of directors as of the close of the last preceding year. Collections of the stabilization reserve fund charge shall continue until such time as the net balance of the stabilization reserve fund is not less than the projected sum of premiums to be written in the year following valuation date. The fund shall be credited with all stabilization reserve fund charges collected from policyholders and shall be charged with any deficit from the prior year's operation of the association."

Sec. 22.10. Section 5, Article 21.49-3, Insurance Code, is amended to read as follows:

"Section 5. PARTICIPATION. (a) Each policyholder shall have contingent liability for a proportionate share of any assessment of policyholders made under the authority of this article. Whenever a deficit, as calculated pursuant to the plan of operation, is sustained by the association in any one year, its directors shall levy an assessment only upon those policyholders who held policies in force at any time within the two most recently completed calendar years in which the association was issuing policies preceding the date on which the assessment was levied. The aggregate amount of the assessment shall be equal to that part of the deficit not recouped from the stabilization reserve fund. The maximum aggregate assessment per policyholder shall not exceed the annual premium for the liability policy most recently in effect. Subject to such maximum limitation, each policyholder shall be assessed for that portion of the deficit reflecting the proportion which the earned premium on the policies of such policyholder bears to the total earned premium for all policies of the association in the two most recently completed calendar years.

"(b) All insurers which are members of the association shall participate in its writings, expenses, [~~profits,~~] and losses in the proportion that the net direct premiums, as defined herein, of each such member, excluding that portion of premiums attributable to the operation of the association, written during the preceding calendar year bears to the aggregate net direct premiums written in this state by all members of the association. Each insurer's participation in the association shall be determined annually on the basis of such net direct premiums written during the preceding calendar year, as reported in the annual statements and other reports filed by the insurer that may be required by the board. No member shall be obligated in any one year to reimburse the association on account of its proportionate share in the deficit from operations of the association in that year in excess of one percent of its surplus to policyholders and the aggregate amount not so reimbursed shall be reallocated among the remaining members in accordance with the method of determining participation prescribed in this subdivision, after excluding from the computation the total net direct premiums of all members not sharing in such excess deficit. In the event that the deficit from operations allocated to all members of the association in any calendar year shall exceed one percent of

their respective surplus to policyholders, the amount of such deficit shall be allocated to each member in accordance with the method of determining participation prescribed in this subdivision."

Sec. 22.11. Section 11, Article 21.49-3, Insurance Code, is amended to read as follows:

"Section 11. DISSOLUTION OF THE ASSOCIATION. Upon the effective date of this article, the board shall, after consultation with the joint underwriting association, representatives of the public, the Texas Medical Association, the Texas Podiatry Association, the Texas Hospital Association, and other affected individuals and organizations, promulgate a plan of dissolution consistent with the provisions of this article, to become effective and operative on December 31, 1979, unless the board determines before that time that the association is no longer needed to accomplish the purposes for which it was created and orders its dissolution, in which case, the plan of dissolution shall become effective on the date of dissolution ordered by the board [~~the expiration of this Act~~]. The plan of dissolution shall contain provisions for maintaining reserves for losses which may be reported subsequent to the expiration of all policies in force. If, at the expiration of five years and annually thereafter, if necessary, from December 31, 1979, or the date of dissolution ordered by the board, [~~the expiration date of this Act~~] the board finds, after notice and hearing, that all known claims have been paid or otherwise disposed of by the association, then the board may wind up the affairs of the association by paying [~~distributing to the members of the association any profits remaining after payment~~] to a special fund created by the statutory liquidator of the board a reasonable reserve to be administered by said liquidator for unknown claims; reimbursing assessments and contributions of members in accordance with Section 4(b)(5) of this article, and distributing the remainder to the policyholders ratably in proportion to premiums and assessments paid during or after the last two years in which the association was issuing policies. If such reserve fund administered by the statutory liquidator proves inadequate, the association shall be treated as an insolvent insurer in respect to the application of the provisions of Article 21.28-C, Property and Casualty Insurance Guaranty Act, Insurance Code. Notice of claim shall be made upon the board."

Sec. 22.12. Article 21.49-3, Insurance Code, is amended by adding Sections 12 and 13 to read as follows:

"Section 12. AUTHORITY OF THE BOARD OVER DISSOLUTION. Before December 31, 1979, if the board finds that the association is no longer needed to accomplish the purposes for which it was created, the board may issue an order dissolving the association as of a certain date stated in the order.

"Section 13. TERMINATION OF POLICIES. After December 31, 1979, if no earlier dissolution date is ordered by the board, or after the date ordered for dissolution by the board, no policies will be issued by the association. All then issued policies shall continue in force until terminated in accordance with the terms and conditions of such policies."

Sec. 22.13. The Insurance Code, as amended, is amended by adding Article 21.49-4 to read as follows:

"Article 21.49-4. SELF-INSURANCE TRUSTS

"(a) In this article:

"(1) 'Physician' means a person licensed to practice medicine in this state.

"(2) 'Health care liability claim' means a cause of action against a physician for treatment, lack of treatment, or other claimed departure from accepted standards of health care or safety which proximately results in injury to or death of the patient, whether the patient's claim or cause of action sounds in tort or contract.

"(b) An association of physicians organized on a statewide basis for purposes other than the purchase of insurance protection against health care liability claims,

which has been in continuing existence for a period of at least two years prior to the effective date of this article may create a trust to self-insure physicians who are members of the association against health care liability claims on complying with the following conditions:

"(1) establishment of a health care liability claims trust fund or other agreements to provide coverage against health care liability claims and related risks; and

"(2) employment of appropriate professional staff and consultants for program management.

"(c) The trust may purchase, on behalf of the members of the organizing association, medical professional liability insurance, specific excess insurance, aggregate excess insurance, and reinsurance, as in the opinion of the trustees are necessary. The trust fund is further authorized to purchase such risk management services as may be required and pay claims that arise under any deductible provisions.

"(d) The trust investment powers and limitations shall be the same as those of any state bank with trust powers. The trust shall adopt rules and regulations to guarantee all contingent liabilities in the event of dissolution.

"(e) The trust is not engaged in the business of insurance under this code and other laws of this state and the provisions of any chapters or sections of this code are declared inapplicable to a trust organized and operated under this article, provided that the State Board of Insurance may require any trust created under this article to satisfy reasonable minimum requirements to insure the capability of the trust to satisfy its contractual obligations."

PART 4. OTHER PROVISIONS

Sec. 23.01. The provisions of this Act shall apply only to causes of action based on health care liability claims accruing after the effective date of this Act.

Sec. 23.02. This Act expires at midnight on August 31, 1993.

Sec. 23.03. Article 5.82, Insurance Code, and Section 3, Chapter 331, Acts of the 64th Legislature, Regular Session, 1975, are repealed.

Sec. 23.04. The importance of this legislation and the crowded condition of the calendars in both houses create an emergency and an imperative public necessity that the constitutional rule requiring bills to be read on three several days in each house be suspended, and this rule is hereby suspended.

SCHWARTZ
FARABEE

The amendment was read.

Senator Farabee offered the following amendment to the pending amendment:

Amend Amendment No. 1 to the Committee Substitute for **H.B. 1048** so as to strike all of Subchapter L (Sections 12.01-12.05) therefrom and substitute in lieu thereof the following:

"SUBCHAPTER L. LIABILITY LIMITS

"Section 12.01. DEFINITION. In this section, 'consumer price index' means the index published by the Bureau of Labor Statistics of the United States Department of Labor that measures the average change in prices of goods and services purchased by urban wage earners and clerical workers' families and single workers living alone.

"Sec. 12.02. LIMIT ON CIVIL LIABILITY.

"(a) In an action on a health care liability claim where final judgment is rendered against a physician or health care provider, the limit of civil liability for damages of the physician or health care provider shall be limited to an amount not to exceed $500,000; provided further that this amount shall not include more than $100,000 for all past and future nonecomomic losses recoverable by or on behalf of any injured person and/or the estate of such person, including without limitation as applicable past and future physical pain and suffering, mental anguish and suffering, consortium, disfigurement and any other non-pecuniary damage;

"(b) Subsection (a) of this section does not apply to the amount of damages awarded on a health care liability claim for the expenses of necessary medical, hospital, and custodial care received before judgment or required in the future for treatment of the injury.

"(c) This section shall not limit the liability of any insurer where facts exist that would enable a party to invoke the common law theory of recovery commonly known in Texas as the 'Stowers Doctrine.'

"(d) In any action on a health care liability claim that is tried by a jury in any court in this state, the following shall be included in the court's written instructions to the jurors: Do not consider, discuss, nor speculate whether or not liability, if any, on the part of any party is or is not subject to any limit under applicable law.

"Sec. 12.03. ALTERNATIVE PARTIAL LIMIT ON CIVIL LIABILITY. In the event that Section 12.02(a) of this subchapter is stricken from this subchapter or is otherwise invalidated by a method other than through legislative means, the following shall become effective:

"In an action on a health care liability claim where final judgment is rendered against a physician or health care provider, the limit of civil liability of the physician or health care provider for all past and future noneconomic losses recoverable by or on behalf of any injured person and/or the estate of such person, including without limitation as applicable past and future physical pain and suffering, mental anguish and suffering, consortium, disfigurement and any other non-pecuniary damage, shall be limited to an amount not to exceed $100,000.

"Sec. 12.04. ADJUSTMENT OF LIABILITY LIMITS. When there is an increase or decrease in the consumer price index with respect to the amount of that index on the effective date of this subchapter each of the liability limits prescribed in Section 12.02(a) or in Section 12.03 of this subchapter, as applicable, shall be increased or decreased, as applicable, by a sum equal to the amount of such limit multiplied by the percentage increase or decrease in the consumer price index between the effective date of this subchapter and the time at which damages subject to such limits are awarded by final judgment or settlement.

"Sec. 12.05. SUBCHAPTERS APPLICATION PREVAILS OVER CERTAIN OTHER LAWS. The provisions of this subchapter shall apply notwithstanding the provisions contained in Article 4671, Revised Civil Statutes of Texas, 1925, as amended, and the provisions of Article 5525, Revised Civil Statutes of Texas, 1925, as amended."

The amendment to the pending amendment was read.

Senator Schwartz moved to table the amendment to the pending amendment.

The motion to table was lost by the following vote: Yeas 11, Nays 20.

Yeas: Clower, Doggett, Hance, Jones of Harris, Kothmann, Longoria, Mauzy, Ogg, Parker, Schwartz, Truan.

Nays: Adams, Aikin, Andujar, Braecklein, Brooks, Creighton, Farabee, Harris, Jones of Taylor, Lombardino, McKnight, Meier, Mengden, Moore, Patman, Santiesteban, Sherman, Snelson, Traeger, Williams.

The amendment to the pending amendment was then adopted.

RECORD OF VOTES

Senators Schwartz, Doggett, Mauzy, and Jones of Harris asked to be recorded as voting "Nay" on the adoption of the amendment to the pending amendment.

Senator Meier offered the following amendment to the pending amendment:

Amend Amendment No. 1 to the Committee Substitute for **H.B. 1048** so as to delete Subsection (1) of Section 2.11 of Subchapter B (Additional Disciplinary Powers) therefrom and substitute the following new Subsection (1) in lieu thereof, retain the present Section (2) and adding a new Subsection (3) to said Section 2.11 to read as follows:

"(1) Professional failure to practice medicine in an acceptable manner consistent with public health and welfare; or"

"(3) Repeated or recurring meritorious health care liability claims which in the opinion of the Board evidence professional incompetence likely to injure the public."

The amendment to the pending amendment was read.

(Senator Aikin in Chair)

Senator Schwartz moved to table the amendment to the pending amendment.

(President in the Chair)

The motion to table was lost by the following vote: Yeas 5, Nays 26.

Yeas: Braecklein, Clower, Jones of Harris, Schwartz, Sherman.

Nays: Adams, Aikin, Andujar, Brooks, Creighton, Doggett, Farabee, Hance, Harris, Jones of Taylor, Kothmann, Lombardino, Longoria, Mauzy, McKnight, Meier, Mengden, Moore, Ogg, Parker, Patman, Santiesteban, Snelson, Traeger, Truan, Williams.

The amendment to the pending amendment was then adopted.

Question - Shall the pending amendment be adopted?

RECESS

On motion of Senator Aikin the Senate at 12:05 o'clock p.m. took recess until 1:30 o'clock p.m. today.

AFTER RECESS

The Senate met at 1:30 o'clock p.m. today and was called to order by the President.

LEAVE OF ABSENCE

Senator McKnight was granted leave of absence for the remainder of today on account of important business on motion of Senator Lombardino.

COMMITTEE SUBSTITUTE HOUSE BILL 1048 ON SECOND READING

The Senate resumed consideration of pending business, same being **C.S.H.B. 1048** as amended on its second reading and passage to third reading, with an amendment pending.

Question - Shall the pending amendment be adopted?

Senator Creighton offered the following amendment to the pending amendment:

Amend Amendment No. 1 to the Committee Substitute for **H.B. 1048** so as to delete from Section 11.01 of Subchapter K (Statute of Limitations) thereof the following (at line 7 of page 33):

"12th" and "14th"

and substitute in lieu thereof the following:

"6" and "8th".

The amendment to the pending amendment was read.

On motion of Senator Schwartz the amendment to the pending amendment was tabled by the following vote: Yeas 15, Nays 14, Paired Vote 1.

Yeas: Brooks, Clower, Doggett, Jones of Harris, Kothmann, Mauzy, Ogg, Parker, Patman, Santiesteban, Schwartz, Snelson, Traeger, Truan, Williams.

Nays: Adams, Aikin, Andujar, Braecklein, Creighton, Farabee, Harris, Jones of Taylor, Lombardino, Longoria, Meier, Mengden, Moore, Sherman.

Absent-excused: McKnight.

PAIRED VOTE

Senator Hance (present), who would vote "Yea", with Senator McKnight (absent), who would vote "Nay".

Senator Creighton offered the following amendment to the pending amendment:

Amend Amendment No. 1 to the Committee Substitute for **H.B. 1048** so as to delete from Section 11.01 of Subchapter K (Statute of Limitations) thereof the following (at lines 1-4 of page 15) :

"that, minors under the age of 12 years shall have until their 14th birthday in which to file, or have filed on their behalf, such claim."

and substitute in lieu thereof the following:

"that minors between the ages of 6 and 12 shall have until their 14th birthday or until two years from the date either the minor or his or her parent or legal guardian discovered or should have discovered the breach or the tort complained of, whichever occurs earlier, in which to file, or have filed on their behalf, such claim."

The amendment to the pending amendment was read.

On motion of Senator Schwartz the amendment to the pending amendment was tabled by the following vote: Yeas 16, Nays 13, Paired Vote 1.

Yeas: Adams, Aikin, Brooks, Clower, Doggett, Jones of Harris, Kothmann, Mauzy, Ogg, Parker, Patman, Santiesteban, Schwartz, Snelson, Truan, Williams.

Nays: Andujar, Braecklein, Creighton, Farabee, Harris, Jones of Taylor, Lombardino, Longoria, Meier, Mengden, Moore, Sherman, Traeger.

Absent-excused: McKnight.

PAIRED VOTE

Senator Hance (present), who would vote "Yea", with Senator McKnight (absent), who would vote "Nay".

Senator Farabee offered the following amendment to the pending amendment:

Amend Amendment No. 1 to the Committee Substitute for **H.B. 1048** by striking all of Subchapter H (Health Care Screening Panels; Sections 8.01-8.16) therefrom. The balance of the subchapters in Part 1 of said amendment and bill to be renumbered accordingly.

The amendment to the pending amendment was read.

Senator Ogg offered the following substitute for the amendment to the pending amendment:

Amend House Bill 1048 by striking Subchapter H of Part 1 in its entirety and substituting the following in lieu thereof:

SUBCHAPTER H. SCREENING HEALTH CARE LIABILITY CLAIMS.

Sec. 8.01. APPOINTMENT OF MASTER. In a claim filed prior to suit, either the patient or the health care provider may request the presiding judge of the administrative judicial district where the health care services were performed to assign a claim to any district court in the administrative district where an impartial forum may be obtained that is reasonably convenient to the parties. The district judge receiving such request shall promptly appoint an impartial master. If either party objects to the master appointed in writing within 10 days, the court will appoint another master, which shall be subject to the written objection within 10 days of any party who approved the first appointment, whereupon the court will appoint a third master, not subject to further objection. The request shall be in writing, setting forth the names and addresses of the parties, the nature of the dispute, the amount of loss alleged, the date and place of the services rendered, and certified copies of the requests are to be sent to the other party.

Sec. 8.02. VENUE. Suit may be filed where there is no claim pending before the presiding judge of the administrative district, in any district court of the county where the health care services were performed, or any county immediately adjacent thereto. Either the patient or the health care provider may move the court where the suit is filed to appoint an impartial master. Each side of the dispute has the right to only one summary challenge to a master appointed by the court, which must be made in writing to the court within ten days of the appointment, and the court will continue to appoint masters until such challenges are exhausted or until a master is appointed.

Sec. 8.03. PROCEEDINGS BY MASTER. The master shall:

(1) hold an informal hearing within 30 days, or as soon thereafter as is convenient with all parties and the master;

(2) have all powers granted to conduct hearings that are granted to masters in chancery by the Texas Rules of Civil Procedure; and

(3) file written findings as to whether or not professional malpractice or substandard or negligent practices or omissions existed that were a proximate cause of legal damages, and the amount of such legal damages, with the judge who appointed him, with certified copies going to all parties by certified mail. If either party is dissatisfied with the master's findings, said party must file notice of dissatisfaction with the judge within 20 days of the filing of the master's report with the court, otherwise, the court shall enter judgement on the master's findings.

(4) In the event suit has not been filed, the party filing notice of dissatisfaction has 20 days after filing said notice to file suit in the court in which the master's findings and the notice of dissatisfaction have been filed. However, if suit is not filed within 20 days, judgement shall be entered on the master's findings unless for good cause, the time is extended at the trial court's discretion.

Sec. 8.04. TRIAL DE NOVO. Either party has an absolute right of appeal trial de novo from the findings of the master, if perfected according to the procedures set forth herein. The presiding judge who appointed the master in any case shall not hear such case on a trial de novo appeal.

Sec. 8.05. COSTS. The trial court, at its discretion, may upon entering judgement in a trial de novo of a health care liability claim, after findings of a master have been filed and objected to or appealed from, assess, in addition to the costs of court, the reasonable attorney's fees of opposing counsel against the party and his counsel, who have not reversed an unfavorable finding of the master on the issue of any health care liability claim, especially for frivolous appeals, and the court may require the filing of the bond to cover such expense.

Sec. 8.06. JOINDER OF PARTIES. Companion causes of action arising out of the same occurrence as the health care liability disputes herein against joint tort feasors may be joined with the claims and causes herein, and shall be subject to the same procedures.

Sec. 8.07. STANDARD APPLIED BY THE MASTER. The standard to be applied by the master to the issue of malpractice or substandard professional practice or professional negligence, is the prevailing standard of duty, practice, or care applicable in civil actions based on professional responsibility and liability.

Sec. 8.08. ADMISSIBILITY OF MASTER'S FINDINGS. None of the findings of the master shall be admissible into evidence in any trial where either party requests a trial de novo.

Sec. 8.09. STATUTE OF LIMITATIONS. (a) unless the time for completion is extended by written agreement by all parties, all proceedings by a master under this subchapter shall be completed within six months from the date of the request by either party, whether or not a decision has been reached by the panel.

(b) a request for a master for a health care liability claim tolls the applicable statute of limitations for filing suit, until 30 days following receipt of the decision of

the master or 30 days following termination of the panel as provided in subsection (a) of this section.

Sec. 8.10. REPORT. (a) The administrative judge shall transmit to the State Board of Insurance and the applicable licensing board of any defendant party a copy of the request for a master within 10 days of filing. The reports shall be filed for informational purposes and making or filing other reports shall not of itself be grounds for discipline.

(b) The administrative judge shall likewise transmit to the State Board of Insurance and the applicable licensing board of the defendant party a copy of the master's report within 10 days of filing. The State Board of Insurance and the applicable licensing board of any defendant may take such action based on the master's decision as is appropriate under applicable law.

Sec. 8.11. DESIGNATION OF DISTRICT. For the purposes of this subchapter, Rockwall County shall be considered a part of the first administrative judicial district.

The substitute for the amendment to the pending amendment was read.

On motion of Senator Farabee the substitute for the amendment to the pending amendment was tabled by the following vote: Yeas 21, Nays 9.

Yeas: Adams, Aikin, Andujar, Braecklein, Creighton, Doggett, Farabee, Hance, Harris, Jones of Taylor, Kothmann, Lombardino, Mengden, Moore, Parker, Patman, Santiesteban, Schwartz, Sherman, Snelson, Traeger.

Nays: Brooks, Clower, Jones of Harris, Longoria, Mauzy, Meier, Ogg, Truan, Williams.

Absent-excused: McKnight.

Senator Schwartz moved to table the amendment to the pending amendment.

The motion to table was lost by the following vote: Yeas 11, Nays 18, Paired Vote 1.

Yeas: Adams, Clower, Jones of Harris, Kothmann, Longoria, Mauzy, Ogg, Santiesteban, Schwartz, Sherman, Truan.

Nays: Aikin, Andujar, Braecklein, Brooks, Creighton, Doggett, Farabee, Harris, Jones of Taylor, Lombardino, Meier, Mengden, Moore, Parker, Patman, Snelson, Traeger, Williams.

Absent-excused: McKnight.

PAIRED VOTE

Senator Hance (present), who would vote "Yea", with Senator McKnight (absent), who would vote "Nay".

The amendment to the pending amendment was then adopted.

RECORD OF VOTES

Senators Mauzy and Truan asked to be recorded as voting "Nay" on the adoption of the amendment to the pending amendment.

Senator Farabee offered the following amendment to the pending amendment:

Amend Amendment No. 1 to the Committee Substitute for **H.B. 1048** by adding Part 1 thereof a new subchapter. Said new subchapter to be added on page 35 after the existing Subchapter M in said amendment and bill. Said new subchapter to be appropriately numbered and the balance of said Part 1 in said amendment and bill to be renumbered accordingly. Said new subchapter to read as follows:

"SUBCHAPTER ___. COLLATERAL SOURCES

"Section ____. DEFINITION. As used in this section 'collateral source' means any payments made or to be made to a claimant or on his behalf under:

"(a) the United States Social Security Act, any federal, state, or local income disability or workmen's compensation act, or any other public program providing medical expenses, disability payments, or other benefits;

"(b) health, sickness, or income disability insurance, automobile accident insurance that provides health benefits available to the claimant, whether purchased by him or provided by others (excluding life insurance proceeds);

"(c) a contract or agreement of a group, organization, partnership, or corporation to provide, pay for, or reimburse the costs of hospital, medical, dental, or other health care services;

"(d) a contractual or voluntary wage continuation plan provided by employers or any other system intended to provide wages during a period of disability; and

"(e) other benefits and resources that may be available to the claimant, other than from the personal assets of the claimant or his immediate family.

"Sec. ____. REDUCTION OF AMOUNT OF DAMAGES. In an action against a physician or health care provider based on a health care liability claim, on admission or determination of liability on the part of the physician or health care provider and the award of damages, the presiding judge in the case shall reduce the amount of the damage award by the total of all amounts paid or to be paid to the claimant from all collateral sources available to him.

"Sec. ____. PROOF OF COLLATERAL SOURCES. In determining the amount of the reduction from the award of damages, the presiding judge shall receive evidence from the claimant and any other persons that the court considers appropriate concerning the amounts from collateral sources that have been paid or will be paid to the claimant, for the benefit of the claimant, or are made available to the claimant.

"Sec. ____. CREDIT FOR PREMIUMS. At the time the amount of the reduction from the award of damages is determined, the presiding judge shall receive evidence as to the amount of premiums paid by the claimant from his personal assets for insurance coverage by a collateral source and shall offset any reduction in the award of damages by the amount of premiums paid for the insurance coverage for the term of coverage during which the injury occurred.

"Sec. ____. ELIMINATION OF SUBROGATION. Except as provided by law, no insurer or other person providing a collateral source is entitled to recover from the defendant or any other person or entity amounts paid to or on behalf of the claimant as a result of a health care liability claim, and no right of subrogation or assignment of rights of recovery shall exist in favor of the collateral source."

The amendment to the pending amendment was read.

Senator Schwartz moved to table the amendment to the pending amendment.

The motion to table was lost by the following vote: Yeas 14, Nays 15, Paired Vote 1.

Yeas: Aikin, Clower, Creighton, Doggett, Hance, Jones of Harris, Kothmann, Mauzy, Meier, Ogg, Parker, Schwartz, Snelson, Truan.

Nays: Adams, Andujar, Braecklein, Brooks, Farabee, Harris, Jones of Taylor, Lombardino, Longoria, Mengden, Patman, Santiesteban, Sherman, Traeger, Williams.

Absent-excused: McKnight.

PAIRED VOTE

Senator Moore (present), who would vote "Nay", with Senator McKnight (absent), who would vote "Yea".

The amendment to the pending amendment failed of adoption by the following vote: Yeas 13, Nays 16, Paired Vote 1.

Yeas: Adams, Andujar, Braecklein, Farabee, Harris, Jones of Taylor, Lombardino, Longoria, Mengden, Patman, Santiesteban, Sherman, Traeger.

Nays: Aikin, Brooks, Clower, Creighton, Doggett, Hance, Jones of Harris, Kothmann, Mauzy, Meier, Ogg, Parker, Schwartz, Snelson, Truan, Williams.

Absent-excused: McKnight.

PAIRED VOTE

Senator Moore (present), who would vote "Yea", with Senator McKnight (absent), who would vote "Nay".

Senator Farabee offered the following amendment to the pending amendment:

Amend Amendment No. 1 to the Committee Substitute for **H.B. 1048** by adding to Part 1 thereof a new subchapter. Said new subchapter to be added on page 15 after the existing Subchapter M in said amendment and bill. Said new subchapter to be appropriately numbered and the balance of said Part 1 in said amendment and bill to be renumbered accordingly. Said new subchapter to read as follows:

"SUBCHAPTER ____. **COLLATERAL SOURCES**

"Section ____. DEFINITION. As used in this section 'collateral source' means any payments made or to be made to a claimant or on his behalf under:

"(a) the United States Social Security Act, any federal, state, or local income disability or workmen's compensation act, or any other public program providing medical expenses, disability payments, or other benefits;

"(b) health, sickness, or income disability insurance, automobile accident insurance that provides health benefits or income disability coverage, and any other insurance benefits available to the claimant, whether purchased by him or provided by others (excluding life insurance proceeds);

"(c) a contract or agreement of a group, organization, partnership, or corporation to provide, pay for, or reimburse the costs of hospital, medical, dental, or other health care services;

"(d) a contractual or voluntary wage continuation plan provided by employers or any other system intended to provide wages during a period of disability; and

"(e) other benefits and resources that may be available to the claimant, other than from the personal assets of the claimant or his immediate family.

"Sec. _____. ADMISSIBILITY OF EVIDENCE OF COLLATERAL SOURCES. In an action against a physician or health care provider based on a health care liability claim, the physician or health care provider may introduce evidence of any collateral source, as defined in this subchapter, which has been paid or will be paid in reasonable probability to or on behalf of any or all claimants as a result of the injury or death made the basis of such health care liability claim.

"Sec. _____. PURPOSE AND WEIGHT OF EVIDENCE OF COLLATERAL SOURCES. Such evidence shall be admissible for the purpose of considering the amount of damages to be awarded to the claimant or claimants, jointly or severally. This evidence may be accorded such weight as the trier of fact chooses to give it, and the trier of fact shall be so instructed."

The amendment to the pending amendment was read.

On motion of Senator Schwartz the amendment to the pending amendment was tabled by the following vote: Yeas 19, Nays 10.

Yeas: Adams, Aikin, Braecklein, Brooks, Clower, Creighton, Doggett, Hance, Jones of Harris, Kothmann, Mauzy, Meier, Ogg, Parker, Santiesteban, Schwartz, Snelson, Truan, Williams.

Nays: Andujar, Farabee, Harris, Jones of Taylor, Lombardino, Longoria, Mengden, Patman, Sherman, Traeger.

Absent: Moore.

Absent-excused: McKnight.

Senator Farabee offered the following amendment to the pending amendment:

Amend Amendment No. 1 to the Committee Substitute for **H.B. 1048** by adding to Part 1 thereof a new subchapter. Said new subchapter to be added on page 15 after the existing Subchapter M in said amendment and bill. Said new subchapter to be appropriately numbered and the balance of said Part 1 in said amendment and bill to be renumbered accordingly. Said new subchapter to read as follows:

"SUBCHAPTER ____. **COLLATERAL SOURCES**

"Section ____. DEFINITION. As used in this article 'collateral source' means:

"(a) Any payments made or to be made to a claimant or on his behalf for expenses for medical, hospital or custodial care with respect to an injury made the basis of a health care liability claim under:

"(1) Any state or local workmen's compensation act providing coverage for such expenses, in whole or in part;

"(2) To the extent permitted by applicable law, any federal program providing coverage for such expenses, in whole or in part;

"(3) Any group insurance policy providing coverage for such expenses, in whole or in part (excluding life insurance proceeds).

"(b) Exemption from federal or state taxation of damages for personal injury or death.

"Sec. _____. ADMISSIBILITY OF EVIDENCE OF CERTAIN COLLATERAL SOURCES. In an action against a physician or health care provider based on a health care liability claim, the physician or health care provider may introduce evidence of any collateral source as defined in this subchapter.

"Sec. _____. PURPOSE AND WEIGHT OF EVIDENCE OF CERTAIN COLLATERAL SOURCES. Such evidence shall be admissible for the purpose of determining the amount of damages to be awarded to the claimant or claimants, jointly or severally. This evidence may be accorded such weight as the trier of fact chooses to give it, and the trier of fact shall be so instructed."

The amendment to the pending amendment was read.

On motion of Senator Schwartz the amendment to the pending amendment was tabled by the following vote: Yeas 15, Nays 14, Paired Vote 1.

Yeas: Aikin, Braecklein, Brooks, Clower, Creighton, Doggett, Hance, Jones of Harris, Kothmann, Mauzy, Ogg, Parker, Schwartz, Snelson, Truan.

Nays: Adams, Andujar, Farabee, Harris, Jones of Taylor, Lombardino, Longoria, Meier, Mengden, Patman, Santiesteban, Sherman, Traeger, Williams.

Absent-excused: McKnight.

PAIRED VOTE

Senator Moore (present), who would vote "Nay", with Senator McKnight (absent), who would vote "Yea".

Senator Farabee offered the following amendment to the pending amendment:

Amend Amendment No. 1 to the Committee Substitute for **H.B. 1048** by adding to Part 1 thereof a new subchapter. Said new subchapter to be added on page 15 after the existing Subchapter M in said amendment and bill. Said new subchapter to be appropriately numbered and the balance of said Part 1 in said amendment and bill to be renumbered accordingly. Said new subchapter to read as follows:

"SUBCHAPTER ____. **ADMISSIBILITY OF CERTAIN EVIDENCE**

"Section ____. ADMISSIBILITY OF CERTAIN EVIDENCE. In any health care liability claim evidence shall be admissible to indicate exemption from federal or state taxation of an award of compensation for personal injury or death.

The amendment to the pending amendment was read.

On motion of Senator Schwartz the amendment to the pending amendment was tabled by the following vote: Yeas 16, Nays 14,.

Yeas: Aikin, Braecklein, Brooks, Clower, Doggett, Hance, Jones of Harris, Kothmann, Longoria, Mauzy, Ogg, Parker, Santiesteban, Schwartz, Snelson, Truan.

Nays: Adams, Andujar, Creighton, Farabee, Harris, Jones of Taylor, Lombardino, Meier, Mengden, Moore, Patman, Sherman, Traeger, Williams.

Absent-excused: McKnight.

Senator Brooks offered the following amendment to the pending amendment:

Amend Amendment No. 1 to the Committee Substitute for **H.B. 1048** by adding to Part 1 thereof a new subchapter. Said new subchapter to be added on page 35 after the existing Subchapter M in said amendment and bill. Said new subchapter to be appropriately numbered and the balance of said Part 1 in said amendment and bill to be renumbered accordingly. Said new subchapter to read as follows:

"SUBCHAPTER ____. **COLLATERAL SOURCES**

"Section ___. DEFINITION. As used in this section 'collateral source' means any payments made or to be made to a claimant or on his behalf under:

"(a) health, sickness, or automobile accident insurance that provides health benefits, and any other health insurance benefits available to the claimant, whether purchased by him or provided by others (excluding life insurance proceeds)."

"Sec. _____. ADMISSIBILITY OF EVIDENCE OF CERTAIN COLLATERAL SOURCES. In an action against a physician or health care provider based on a health care liability claim, the physician or health care provider may introduce evidence of any collateral source as defined in this subchapter.

"Sec. ____. PURPOSE AND WEIGHT OF EVIDENCE OF CERTAIN COLLATERAL SOURCES. Such evidence shall be admissible for the purpose of determining the amount of damages to be awarded to the claimant or claimants, jointly or severally. This evidence may be accorded such weight as the trier of fact chooses to give it, and the trier of fact shall be so instructed."

The amendment to the pending amendment was read.

(Senator Adams in Chair)

On motion of Senator Brooks and by unanimous consent, the amendment to the pending amendment was withdrawn.

Senator Doggett offered the following amendment to the pending amendment:

Amend Amendment No. 1 to the Committee Substitute for **H.B. 1048** by adding to Part 1 thereof a new subchapter. Said new subchapter to be added on page 35 after the existing Subchapter M in said amendment and bill. Said new subchapter to be appropriately numbered and the balance of said Part 1 in said amendment and bill to be renumbered accordingly. Said new subchapter to read as follows:

"SUBCHAPTER ____. **COLLATERAL SOURCES**

"Section ___. DEFINITION. As used in this section 'collateral source' means any payments made or to be made to a claimant or on his behalf under:

"(a) health, sickness, or automobile accident insurance that provides health benefits, and any other health insurance benefits available to the claimant, whether purchased by him or provided by others (excluding life insurance proceeds)."

"Sec. ____. REDUCTION OF AMOUNT OF DAMAGES. In an action against a physician or health care provider based on a health care liability claim, on admission or determination of liability on the part of the physician or health care provider and the award of damages, the presiding judge in the case may reduce the amount of the damage award by the total of all amounts paid or to be paid to the claimant from all collateral sources, as defined herein, available to him.

"Sec. ____. PROOF OF COLLATERAL SOURCES. In determining the amount of the reduction from the award of damages, the presiding judge may receive evidence from the claimant and any other persons that the court considers appropriate concerning the amounts from collateral sources that have been paid or will be paid to the claimant, for the benefit of the claimant, or are made available to the claimant.

"Sec. ____. CREDIT FOR PREMIUMS. At the time the amount of the reduction from the award of damages is determined, the presiding judge shall receive evidence as to the amount of premiums paid by the claimant from his personal assets for insurance coverage by a collateral source and shall offset any reduction in the award of damages by the amount of premiums paid for the insurance coverage for the term of coverage during which the injury occurred.

"Sec. ____. ELIMINATION OF SUBROGATION. Except as provided by law, no insurer or other person providing a collateral source is entitled to recover from the defendant or any other person or entity amounts paid to or on behalf of the claimant as a result of a health care liability claim, and no right of subrogation or assignment of rights of recovery shall exist in favor of the collateral source."

The amendment to the pending amendment was read.

Senator Schwartz moved to table the amendment to the pending amendment.

The motion to table was lost by the following vote: Yeas 9, Nays 21.

Yeas: Aikin, Clower, Creighton, Jones of Harris, Kothmann, Mauzy, Parker, Schwartz, Truan.

Nays: Adams, Andujar, Braecklein, Brooks, Doggett, Farabee, Hance, Harris, Jones of Taylor, Lombardino, Longoria, Meier, Mengden, Moore, Ogg, Patman, Santiesteban, Sherman, Snelson, Traeger, Williams.

Absent-excused: McKnight.

The amendment to the pending amendment was then adopted.

RECORD OF VOTES

Senators Mauzy and Truan asked to be recorded as voting "Nay" on the adoption of the amendment to the pending amendment.

Senator Farabee offered the following amendment to the pending amendment:

Amend Amendment No. 1 to the Committee Substitute for **H.B. 1048** by adding to Part 1 thereof a new subchapter. Said new subchapter to be added on page 35 after the existing Subchapter M in said amendment and bill. Said new

subchapter to be appropriately numbered and the balance of said Part 1 in said amendment and bill to be renumbered accordingly. Said new subchapter to read as follows:

"SUBCHAPTER ____. STRUCTURED AWARDS

"Section ____. LUMP SUM AWARDS. Except as provided in the next section of this subchapter a final award of damages in a court action to a person with a health care liability claim against a physician or health care provider shall be in a lump sum on final disposition of the suit.

"Sec. ___. STRUCTURED AWARDS IN CERTAIN CASES. In a court action for damages based on a malpractice claim, if the final damage award exceeds a total of $100,000 for all categories of future damages, the damages for future pain and suffering, future medical expenses, and future loss of earning capacity shall be paid in periodic payments in the manner, in the amounts, and over the period of time determined by the judge presiding in the action.

"Sec. _____. TOTAL AMOUNT OF PERIODIC PAYMENTS. Final awards of damages that are made for future pain and suffering, future medical expenses, and future loss of earning capacity shall establish the total amount due the claimant for each of these purposes, and the total amount of all periodic payments made for future pain and suffering, future medical expenses, and future loss of earning capacity shall not exceed the total awards of damages made for each of these purposes respectively.

"Sec. ____. TERMINATION OF CERTAIN PERIODIC PAYMENTS. No devisee, legatee, heir, or estate of a claimant covered by this Act has a claim to recover the remaining portion of the total award of damages for future pain and suffering and future medical expenses not paid to the claimant entitled to them at the time of his death, and no damages for future pain and suffering and future medical expenses remaining unpaid at the death of a claimant entitled to them may be paid to a devisee, legatee, heir, or the estate of the claimant.

"Sec. _____. LUMP SUM SATISFACTION OF CERTAIN PERIODIC PAYMENTS. The damages for future loss of earning capacity not paid at the time of the death of the claimant entitled to them shall be paid to a devisee, legatee, heir, or the estate of the claimant in a lump-sum amount based on its present discounted value as determined by the court in which the original damage award was made."

The amendment to the pending amendment was read.

Senator Schwartz moved to table the amendment to the pending amendment.

(President in Chair)

The motion to table was lost by the following vote: Yeas 14, Nays 14, Paired Vote 1.

Yeas: Adams, Aikin, Braecklein, Brooks, Clower, Doggett, Jones of Harris, Kothmann, Longoria, Mauzy, Ogg, Parker, Schwartz, Truan.

Nays: Andujar, Creighton, Farabee, Harris, Jones of Taylor, Lombardino, Meier, Mengden, Patman, Santiesteban, Sherman, Snelson, Traeger, Williams.

Absent: Moore.

Absent-excused: McKnight.

PAIRED VOTE

Senator Hance (present), who would vote "Yea", with Senator McKnight (absent), who would vote "Nay".

The President announced he would vote "Nay" on the motion to table the amendment to the pending amendment.

The amendment to the pending amendment failed of adoption by the following vote: Yeas 14, Nays 15, Paired Vote 1.

Yeas: Andujar, Creighton, Farabee, Harris, Jones of Taylor, Lombardino, Meier, Mengden, Moore, Patman, Sherman, Snelson, Traeger, Williams.

Nays: Adams, Aikin, Braecklein, Brooks, Clower, Doggett, Jones of Harris, Kothmann, Longoria, Mauzy, Ogg, Parker, Santiesteban, Schwartz, Truan.

Absent-excused: McKnight.

PAIRED VOTE

Senator Hance (present), who would vote "Nay", with Senator McKnight (absent), who would vote "Yea".

Senator Farabee offered the following amendment to the pending amendment:

Amend Amendment No. 1 to the Committee Substitute for **H.B. 1048** by adding to Part 1 thereof a new subchapter. Said new subchapter to be added on page 35 after the existing Subchapter M in said amendment and bill. Said new subchapter to be appropriately numbered and the balance of said Part 1 in said amendment and bill to be renumbered accordingly. Said new subchapter to read as follows:

"SUBCHAPTER ____. **STRUCTURED AWARDS**

"Section ____. DEFINITIONS. As used in this section, unless a different meaning appears from the context:

"(1) 'Periodic payments' means the payment of money or delivery of other property to the judgment creditor at intervals.

"(2) 'Judgment creditor' means the injured plaintiff for whom a judgment is entered based on a health care liability claim, and 'Judgment debtor' includes each physician or health care provider against whom such judgment is entered.

"Sec. ____. LEGISLATIVE INTENT. It is the intent of the legislature in enacting this section to authorize the entry of judgments with respect to health care liability claims so as to provide for the payment of substantial future damages through periodic payments, rather than lump-sum payments. By authorizing periodic payment judgments, it is the further intent of the legislature that the courts will structure such awards in the best interests of injured plaintiff and such other persons, if any, as may be entitled to all or part thereof. It is also the intent of the legislature that all elements of the periodic payment program be specified with certainty in the judgment ordering such payments so that the judgment will have finality and not be subject to subsequent litigation.

"Sec. ____. STRUCTURED AWARDS IN CERTAIN CASES. In any health care liability claim a district court shall, at the request of either party, enter a judgment ordering that money damages or its equivalent for damages of the judgment creditor be paid in whole or in part by periodic payments over a period of time not less than five nor more than ten years, rather than by a lump-sum payment if the award exceeds $100,000.

"Sec. ___. DETERMINATION OF PERIODIC PAYMENTS. In all such judgments ordering the payment of damages by periodic payments, the court shall make specific findings as to the number of payments and dollar amount of each, the interval between payments or the period of time over which payments shall be made in accordance with the preceding paragraph, and the recipient or recipients of such payments.

"Sec. ___. SECURITY FOR PERIODIC PAYMENTS. As a condition to authorizing such periodic payments of future damages, the court shall require the judgment debtor to purchase a paid-up annuity policy from an insurer licensed to do business in this state that is adequate to fund payment of such periodic payments."

The amendment to the pending amendment was read.

Senator Schwartz moved to table the amendment to the pending amendment.

The motion to table was lost by the following vote: Yeas 15, Nays 15.

Yeas: Adams, Aikin, Braecklein, Clower, Doggett, Hance, Jones of Harris, Kothmann, Longoria, Mauzy, Ogg, Parker, Santiesteban, Schwartz, Truan.

Nays: Andujar, Brooks, Creighton, Farabee, Harris, Jones of Taylor, Lombardino, Meier, Mengden, Moore, Patman, Sherman, Snelson, Traeger, Williams.

Absent-excused: McKnight.

The President announced he would vote "Nay" on the motion to table the amendment to the pending amendment.

Senator Adams offered the following substitute for the amendment to the pending amendment:

Amend Farabee amendment to Amendment No. 1 to the Committee Substitute for **H.B. 1048** by adding to Part 1 thereof a new subchapter. Said new subchapter to be added on page 35 after the existing Subchapter M in said amendment and bill. Said new subchapter to be appropriately numbered and the balance of said Part 1 in said amendment and bill to be renumbered accordingly. Said new subchapter to read as follows:

"SUBCHAPTER ____. STRUCTURED AWARDS

"Section ____. DEFINITIONS. As used in this section, unless a different meaning appears from the context:

"(1) 'Periodic payments' means the payment of money or delivery of other property to the judgment creditor at intervals.

"(2) 'Judgment creditor' means the injured plaintiff for whom a judgment is entered based on a health care liability claim, and 'judgment debtor' includes each physician or health care provider against whom such judgment is entered.

"Sec. ___. LEGISLATIVE INTENT. It is the intent of the legislature in enacting this section to authorize the entry of judgments with respect to health care liability claims so as to provide for the payment of substantial future damages through periodic payments, rather than lump-sum payments. By authorizing periodic payment judgments, it is the further intent of the legislature that the courts will structure such awards in the best interests of injured plaintiff and such other persons, if any, as may be entitled to all or part thereof. It is also the intent of the legislature that all elements of the periodic payment program be specified with certainty in the judgment ordering such payments so that the judgment will have finality and not be subject to subsequent litigation.

"Sec. _____. STRUCTURED AWARDS IN CERTAIN CASES. In any health care liability claim a district court may, at the request of either party, enter a judgment ordering that money damages or its equivalent for damages of the judgment creditor be paid in whole or in part by periodic payments over a period of time not less than five nor more than ten years, rather than by a lump-sum payment if the award exceeds $100,000.

"Sec. ___. DETERMINATION OF PERIODIC PAYMENTS. In all such judgments ordering the payment of damages by periodic payments, the court shall make specific findings as to the number of payments and dollar amount of each, the interval between payments or the period of time over which payments shall be made in accordance with the preceding paragraph, and the recipient or recipients of such payments.

"Sec. ___. SECURITY FOR PERIODIC PAYMENTS. As a condition to authorizing such periodic payments of future damages, the court shall require the judgment debtor to purchase a paid-up annuity policy from an insurer licensed to do business in this state that is adequate to fund payment of such periodic payments."

The substitute for the amendment to the pending amendment was read.

Question - Shall the substitute for the amendment to the pending amendment be adopted?

MOTION TO ADJOURN

Senator Schwartz moved the Senate stand adjourned until 10:30 o'clock a.m. tomorrow.

The motion was lost by the following vote: Yeas 12, Nays 18.

Yeas: Braecklein, Clower, Doggett, Hance, Harris, Jones of Harris, Kothmann, Mauzy, Ogg, Parker, Schwartz, Truan.

Nays: Adams, Aikin, Andujar, Brooks, Creighton, Farabee, Jones of Taylor, Lombardino, Longoria, Meier, Mengden, Moore, Patman, Santiesteban, Sherman, Snelson, Traeger, Williams.

Absent-excused: McKnight.

MOTION TO RECOMMIT COMMITTEE SUBSTITUTE HOUSE BILL 1048

Senator Schwartz moved that **C.S.H.B. 1048** be recommitted to the Committee on Jurisprudence.

The motion was lost by the following vote: Yeas 7, Nays 23.

Yeas: Clower, Jones of Harris, Kothmann, Mauzy, Santiesteban, Schwartz, Truan.

Nays: Adams, Aikin, Andujar, Braecklein, Brooks, Creighton, Doggett, Farabee, Hance, Harris, Jones of Taylor, Lombardino, Longoria, Meier, Mengden, Moore, Ogg, Parker, Patman, Sherman, Snelson, Traeger, Williams.

Absent-excused: McKnight.

COMMITTEE SUBSTITUTE HOUSE BILL 1048 ON SECOND READING

The Senate resumed consideration of **C.S.H.B. 1048** as amended on its second reading and passage to third reading, with a substitute for the pending amendment pending.

Question - Shall the substitute for the amendment to the pending amendment be adopted?

The substitute for the amendment to the pending amendment was then adopted by the following vote: Yeas 18, Nays 12.

Yeas: Adams, Aikin, Braecklein, Brooks, Clower, Doggett, Hance, Jones of Harris, Kothmann, Longoria, Mauzy, Ogg, Parker, Patman, Schwartz, Sherman, Snelson, Truan.

Nays: Andujar, Creighton, Farabee, Harris, Jones of Taylor, Lombardino, Meier, Mengden, Moore, Santiesteban, Traeger, Williams.

Absent-excused: McKnight.

The amendment to the pending amendment as substituted was then adopted.

Senator Jones of Taylor offered the following amendment to the pending amendment:

Amend Amendment No. 1 to the Committee Substitute for **H.B. 1048** by adding to Part 1 thereof a new subchapter. Said new subchapter to be added on page 35 after the existing Subchapter M in said amendment and bill. Said new subchapter to be appropriately numbered and the balance of said Part 1 in said amendment and bill to be renumbered accordingly. Said new subchapter to read as follows:

"SUBCHAPTER ____. **VOLUNTARY BINDING CONTRACTUAL ARBITRATION.**

"Section ____. APPLICABILITY. The provisions of this Act shall be ıpplicable to the arbitration of any health care liability claim and any dispute, :ontroversy, or issue relating thereto, whether such claim, dispute, controversy, or ssue arises before or after execution of the arbitration agreement.

"Sec. ____ DEFINITIONS. In this Section and Act:

(1) "Administrative judge" means the presiding judge of the administrative ıdicial district in which a demand for arbitration is filed.

(2) "Association" means the American Arbitration Association or other entity organized to arbitrate disputes pursuant to this chapter.

Sec. ____. ARBITRATION AGREEMENT WITH A PHYSICIAN OR NON-HOSPITAL HEALTH CARE PROVIDER.

(a) If offered, a person who receives health care from a physician or non-hospital health care provider may execute an agreement to arbitrate any health care liability claim and any dispute, controversy, or issue relating thereto, arising out of health care rendered by a physician or non-hospital health care provider.

(b) The agreement to arbitrate shall provide that its execution is not a prerequisite to health care or treatment.

(c) The agreement to arbitrate shall provide that any party to the agreement or such authorized representative, by notifying all other parties to the agreement in writing may revoke the agreement within 60 days after execution. Such written notice shall be by acknowledged personal delivery or by depositing same in the United States mail, certified return receipt requested.

(d) An agreement under this section expires one year after its execution and may be renewed by execution of a new agreement or other evidence of such renewal.

(e) The agreement shall contain the following provision in 12-point boldface type immediately above the space for signature of the parties: "This agreement to arbitrate is not a prerequisite to health care and may be revoked within 60 days after execution."

(f) The form of the agreement adopted shall state clearly the details of the agreement and revocation provision. The person receiving health care shall be furnished with either an original or duplicate original of the agreement.

(g) An agreement to arbitrate which includes the provisions of this section is presumed valid.

Sec. __. ARBITRATION AGREEMENT WITH A HOSPITAL. (a) On entry into the hospital, a person who is to receive health care in a hospital may execute an agreement to arbitrate any health care liability claim and dispute, controversy, or issue relating thereto arising out of health care rendered by the hospital. A person receiving emergency health care may be offered the option to arbitrate but shall not be offered the option until after the emergency care or treatment is completed.

(b) The agreement to arbitrate shall provide that its execution is not a prerequisite to health care.

(c) The agreement to arbitrate shall provide that any party to the agreement or such authorized representative, by notifying all other parties to the agreement in writing, may revoke the agreement at any time before the end of the 60 day period following written notice to the patient of his official discharge from the hospital and of his right to revoke the arbitration agreement. The written notice shall be sent by certified mail, return receipt requested.

(d) The agreement shall contain the following provision in 12-point boldface type immediately above the space for signature of the parties: "This agreement to arbitrate is not a prerequisite to health care and may be revoked at any time before the end of 60 days following notice of discharge and right of revocation as provided above."

(e) Notwithstanding the continuing existence of a non-hospital arbitration agreement, all health care, including without limitation surgical and medical procedures, performed by a participating physician or non-hospital health care provider in a hospital shall be covered by the terms and conditions applicable to the agreement between the patient and the hospital. Post-discharge health care in a physician or non-hospital health care provider's office subsequent to discharge from the hospital will be governed by the terms of any existing arbitration agreement between the patient and such physician or non-hospital health care provider.

(f) Each admission to a hospital shall be treated as separate and distinct for the purposes of an agreement to arbitrate but a person receiving outpatient health care may execute an agreement with the hospital which provides for continuation of the agreement for a specific or continuing program of health care under the provisions of Section 3 of this Section.

(g) The form of the agreement shall be furnished to the person receiving health care as provided in Section 3, Subsection (f) of this Section.

(h) An agreement to arbitrate which includes the provisions of this section is presumed valid.

Sec. ____. RIGHTS OF PARTIES IN ARBITRATION. (a) The parties to an arbitration under this Act are entitled to be represented by counsel, to have an opportunity to be heard and present evidence that is material to the dispute, controversy, or issue, and to cross-examine any witnesses.

(b) A party is entitled to appear without counsel and shall be advised by the administrative judge or association of the right to retain or not to retain counsel in a simple concise written form designed to inform the person of the nature and complexity of the proceeding.

Sec. ____. STANDARD APPLIED IN ARBITRATION. The standard applied in an arbitration is the prevailing standard of duty, practice, or care applicable in a civil action.

Sec. ____. DAMAGES AND REMEDIAL CARE. The nature and amount of damages allowed under applicable common or statutory law or remedial care awarded under this Act are without limitation except as otherwise expressly provided by law.

Sec. ____. COSTS OF ARBITRATION. The administrative expense of an arbitration proceeding is $200 per party per case, unless another amount is agreed to by the parties and the arbitration panel or is otherwise ordered by the applicable administrative judge in the exercise of his discretion.

Sec. ____. INITIATION OF ARBITRATION PROCEEDINGS. (a) Unless otherwise covered in the agreement, a person who is a party to an arbitration agreement and who desires to have a dispute, controversy, or issue covered by an arbitration agreement made under this Act brought to arbitration under the agreement shall file with the regional director or comparable officer of the association or administrative judge of the administrative judicial district in which the dispute, controversy, or issue has arisen a written demand for arbitration.

(b) The demand for arbitration shall include:

(1) a brief statement of the facts involved, the names and addresses of all persons involved, and the dates and circumstances under which the dispute, controversy, or issue has arisen;

(2) a statement authorizing the panel to obtain access to all medical and hospital records and information pertaining to the dispute, controversy, or issue and waiving any claim of privacy as to the contents of those records;

(3) a copy of the arbitration agreement under which arbitration is being demanded; and

(4) a demand that an arbitration be held and that an arbitration panel be appointed.

(c) Within five days after receiving the written demand for arbitration, the association or administrative judge shall send by certified mail, return receipt requested, to each health care provider and hospital named in the demand for arbitration a copy of the demand together with notice of the convening of an arbitration panel.

(d) In the event that any suit is filed based, in whole or in part, upon any health care liability claim that is subject to an arbitration agreement before a demand for arbitration is made, then upon such demand being timely made by any

party entitled thereto said suit shall, upon motion and hearing, be abated as to all parties involved in any such arbitration insofar as said suit is based upon such claim, and the arbitration process shall proceed as provided in this Act. Such demand for arbitration shall be timely if made before or within ten days after the filing of the initial responsive pleading in said suit by the party requesting arbitration; otherwise, such arbitration right shall be deemed waived.

Sec. ____. ARBITRATION PANEL. (a) An arbitration under this Act shall be heard by a panel of three arbitrators unless otherwise expressly agreed to by the parties. One arbitrator shall be an attorney, one arbitrator shall be a physician who is preferably but not necessarily from the respondent's medical specialty, and one arbitrator shall be a person who is neither a health care provider, an attorney, nor a representative of a hospital or insurance company. If the case involves a hospital only, a hospital administrator shall be substituted for the physician.

If there is only one party defendant, other than a hospital, it is the intention of this Section that whenever a panelist other than the attorney or person who is neither a doctor, lawyer or representative of a hospital or insurance company, is to be selected that the panelist be of the same class of physician or health care provider as the respondent.

(b) The attorney-arbitrator shall serve as the chairperson for the arbitration panel and shall have jurisdiction over pre-hearing procedures.

(c) Except as otherwise provided in Subsection (f) of this section, arbitrator candidates shall be selected from lists of candidates that shall be prepared by the association or administrative judge. The association or administrative judge shall send simultaneously to each party an identical list of five arbitrator candidates in each of the three categories together with a brief biographical statement on each candidate. A party may strike from each list any name that is unacceptable and shall number the remaining names in order of preference. When the lists are returned to the association or administrative judge, they shall be compared and the first mutually agreeable candidate in each category shall be invited to serve.

(d) If no mutually agreed upon arbitrator is selected for any category, a second list of that category shall be sent pursuant to Subsection (c) of this section.

(e) If a complete panel is not selected by mutual agreement of the parties under Subsections (c) and (d) of this section, the association or administrative judge shall appoint the remainder of the panel on whom agreement has not been reached by the parties. The appointment by the association or administrative judge is subject to challenge by any party for cause, which challenge may allege facts to establish that unusual community or professional pressures will unreasonably influence the objectivity of the panelist. If such request to strike an arbitrator for cause is sustained by the association or administrative judge, a replacement shall be appointed by the association or administrative judge.

(f) The parties shall not be restricted to the arbitrator candidates submitted for consideration. If all parties mutually agree upon a panelist within a designated category, the panelist shall be invited to serve.

Sec. ___. DETERMINATION OF BIAS OF ARBITRATORS. (a) The association or administrative judge shall make an initial screening for bias as may be appropriate and shall require a candidate for a particular case to complete a current personal disclosure statement under oath. In addition to other relevant information, the statement shall disclose any personal acquaintance with any of the parties or their counsel and the nature of the acquaintance. If the statement reveals facts that suggest the possibility of partiality, and if the panelist is proposed by the association or administrative judge, the association or administrative judge shall communicate those facts to the parties.

(b) Any party may propound reasonable questions to an arbitrator candidate if the questions are propounded within 10 days of the receipt of the candidate's

name. The questions shall be propounded through the association or administrative judge and the candidate shall respond promptly to the association or administrative judge.

(c) No party may communicate with a candidate directly or indirectly at any time after the filing of the demand for arbitration except through the association or administrative judge. Any candidate who is aware of such communication shall immediately notify the association or administrative judge.

Sec. ___. PARTIES TO AN ARBITRATION. (a) A minor child is bound by a written agreement to arbitrate disputes, controversies, or issues upon the execution of an agreement on the minor's behalf by a parent or legal guardian. The minor child may not subsequently disaffirm the agreement.

(b) In cases involving a common question of law or fact, if separate arbitration agreements exist between a plaintiff and a number of defendants or between defendants, the disputes, controversies, and issues shall be consolidated into a single arbitration proceeding.

(c) A person who is not a party to the arbitration agreement may join in the arbitration at the request of any party with all the rights and obligations of the original parties. Each party to an arbitration under this Act is deemed to be bound by the joinder of a new party.

Sec. _____. OFFER OF REPARATIONS PRIVILEGED. Any offer of reparations and all communications incidental to an offer made orally or in writing to a patient by or on behalf of a physician, health care provider or hospital before a demand for arbitration or during arbitration is privileged and may not be used by any party at any time to establish liability or measure of damages attributable to the offeror.

Sec. _____. DEPOSITIONS AND DISCOVERY. (a) After the appointment of the panel of arbitrators, the parties to the arbitration may take depositions and obtain discovery regarding to the subject matter of the arbitration, and, to that end, use and exercise the same rights, remedies, and procedures, and be subject to the same duties, liabilities, and obligations in the arbitration with respect to the subject matter, as if the subject matter of the arbitration were pending in a civil action before a district court of this state.

(b) The panel shall conclude the entire proceeding as expeditiously as possible.

(c) Discovery shall commence not later than 20 days after all parties have received a copy of the demand for arbitration and shall be completed within six months after that time.

(d) A party may be granted an extension of time to complete discovery upon a showing that the extension is not the result of neglect and that the extension is necessary in order to avoid substantial prejudice to the rights of the party.

Sec. ___. EXPERT WITNESSES. (a) A party is entitled to disclosure of the name of any expert witness who will be called at the arbitration and may depose the witness.

(b) A party may through interrogation require any other party to identify each person whom the other party expects to call as an expert witness at the hearing to state the subject matter on which the expert is expected to testify, and to state the substance of the facts and opinions to which the expert is expected to testify and a summary of the grounds for each opinion. Upon motion, the panel or its chairperson may order further discovery by other means, subject to such restriction as to scope and such provisions concerning fees and expenses as its chairperson may deem appropriate.

(c) If a party is provided or requests the discovery procedure in Subsection (b) of this section and the provision or request occurs prior to the date on which an expert is given notice for deposition or other discovery is commenced under prevailing civil practice in this state, any further discovery of the expert by any other

party by deposition or otherwise obligates the other party to compensate the expert for such time and expenses in a reasonable amount as may be determined by the panel.

Sec. _____. EVIDENCE AND PROCEDURE. (a) A hearing shall be informal and the rules of evidence shall be provided under the rules of the association or administrative judge except that the panel shall adhere to civil rules of evidence where the failure to do so will result in substantial prejudice to the right of a party.

(b) Testimony shall be taken under oath and a record of the proceedings shall be made by a tape recording. Any party, at that party's expense, may have transcriptions or copies of the recording made or may provide for a written transcript of the proceedings. The cost of any transcription ordered by the panel for its own use shall be deemed part of the cost of the proceedings.

(c) Expert testimony shall not be required but where expert testimony is used it shall be admitted under the same circumstances as in a civil trial and be subject to cross-examination.

(d) The party with the burden of establishing a standard of care and breach of that standard shall establish the standards whether by the introduction of expert testimony, or by other recognized competent proof of the standard and the breach of the standard.

(e) The panel shall accord such weight and probative worth to expert evidence as it deems appropriate. The panel may call a neutral expert on its own motion, which expert witness shall be subject to cross-examination by the parties. The cost of the expert will be deemed a cost of the proceeding.

Sec. ___. SUBPOENAS. (a) The panel or its chairperson in the arbitration proceeding shall, upon application by a party to the proceeding, and may upon its own determination, issue a subpoena requiring a person to appear and be examined with reference to a matter within the scope of the proceeding and to produce books, records, or papers pertinent to the proceeding.

(b) In case of disobedience to the subpoena, the chairperson or a majority of the arbitration panel in the arbitration proceeding may petition a district court of the county in which the inquiry is being held to require the attendance and testimony of the witness and the production of books, papers, and documents.

(c) A district court, in case of contumacy or refusal to obey a subpoena, may issue an order requiring the person to appear and to produce books, records, and papers and give evidence touching the matter in question. Failure to obey the order of the court may be punished by the court as contempt.

Sec. ____. OTHER AUTHORITY OF PANEL. (a) On application of a party to the arbitration, the panel or its chairperson may order the deposition of a witness to be taken for use as evidence and/or discovery in accordance with the rules of the association or as in a civil trial, whichever is applicable. The deposition shall be taken in the manner prescribed by law or court rule for the taking of depositions in civil actions.

(b) In addition to the power of determining the merits of the arbitration, the panel may enforce the rights, remedies, procedures, duties, liabilities, and obligations of discovery by the imposition of the same terms, conditions, consequences, liabilities, sanctions, and penalties as may be imposed in like circumstances in a civil action by a district court of this state, except the power to order the arrest or imprisonment of a person.

(c) For the purpose of enforcing the duty to make discovery, to produce evidence or information, including books and records, and to produce persons to testify at a deposition or at a hearing, and to impose terms, conditions, consequences, liabilities, sanctions, and penalties upon a party for violation of a duty, a party shall be deemed to include every affiliate of the party as defined in this

section. For that purpose the personnel of an affiliate shall be deemed to be the officers, directors, managing agents, agents, and employees of that party to the same degree as each of them, respectively, bears that status to the affiliate; and the files, books, and records of an affiliate shall be deemed to be in the possession and control of, and capable of production by, the party.

(d) As used in this section, "affiliate" of the party to the arbitration means a party or person for whose immediate benefit the action or proceeding is prosecuted or defended or an officer, director, superintendent, member, agent, employee, or managing agent of that party or person.

Sec. ___. COSTS, FEES, AND MILEAGE. (a) Except for the parties to the arbitration and their agents, officers, and employees, all witnesses appearing pursuant to subpoena are entitled to receive fees and mileage in the same amount and under the same circumstances as prescribed by law for witnesses in civil actions in a district court. The fee and mileage of a witness subpoenaed upon the application of a party to the arbitration shall be paid by that party. The fee and mileage of a witness subpoenaed solely upon the determination of the arbitrator or the majority of a panel of arbitrators shall be paid in the manner provided for the payment of the arbitrator's expenses.

(b) The cost of each arbitrator's fees and expenses, together with any administrative fee, may be assessed against any party in the award or may be assessed among parties in such proportions as may be determined in the arbitration award. Each arbitrator is entitled to receive $50.00 per day for each day actually involved in the activities of the panel, but the total amount paid to any panel member may not be more than $250.00 for all work performed as a member of the panel, unless otherwise agreed to by the parties.

Sec. ___. AWARD. (a) A majority of the panel of arbitrators may grant any relief deemed equitable and just, including without limitation money damages, provision for hospitalization, medical or rehabilitative procedures, support, or any combination of these.

(b) The panel may order submission of written briefs within 30 days after the close of hearings. In written briefs each party may summarize the evidence in testimony and may propose a comprehensive award of remedial or compensatory elements.

(c) The panel shall render its award and opinion within 30 days after the close of the hearing or the receipt of briefs, if ordered.

(d) The award in the arbitration proceeding shall be in writing and shall be signed by the chairperson or by the majority of a panel of arbitrators. The award shall include a determination of all the questions submitted to arbitration by each party, the resolution of which is necessary to determine the dispute, controversy or issue.

(e) To the extent that any arbitration award rendered by the panel is based upon negligence of any party involved in the arbitration proceeding, the panel shall be governed with respect to such award, including without limitation the extent to which each party involved in the arbitration is responsible for such award, by Acts 1973, 63rd Leg., p. 41, ch. 28, Subsection 1, 2 (Art. 2212a, V.A.T.S.) However, such determination shall not affect a claimant's right to recover jointly and severally from all parties not participating in the arbitration where such right otherwise exists in law.

Sec. ___. OPINION. In addition to the award, the panel shall render a written opinion which states its reasoning for the finding of liability or nonliability and the reasoning for the amount and kind of award, if any. A panel member who disagrees with the majority may write a dissenting opinion.

Sec. ___. PAYMENT OF AWARD. (a) In the case of an award, any element of which includes remedial services, contracts, annuities, or other noncash

award element, the panel shall determine the current cash value of each element of the award and shall also determine a total current cash value of the entire award.

(b) An award of remedial surgery or care shall not require that the patient undergo such treatment or care by the physician or health care provider whose conduct resulted in the award.

(c) A claimant need not accept the benefits of an award for remedial surgery or other noncash award element and such refusal shall not affect the claimant's right to receive any other part of the award, nor shall the refusal entitle the claimant to payment of the current cash value of the portion refused except as provided in Subsection (d) and (e) of this section.

(d) Where the total determined current cash value of the entire award is $50,000 or less, any party may satisfy or request satisfaction of all or a designated part of an award by payment in a lump sum of the current cash value of the total award or part of the award so designated.

(e) Where, the total determined current cash value of the entire award is greater than $50,000 the award shall provide that at least one-third, unless otherwise stipulated by the parties, of its total current cash value shall be payable in a cash lump sum, which payment may represent the current cash value of remedial elements of the award or other compensable damages.

Sec. ____. APPEAL. (a) An appeal from the arbitration award shall be under the procedure of the Texas General Arbitration Act and applicable court rules.

(b) On appeal, the court shall vacate an arbitration award if:

(1) the award was procured by corruption, fraud, or other undue means;

(2) there was evident partiality by an arbitrator or corruption in any of the arbitrators or misconduct or willful misbehavior of any of the arbitrators prejudicing the rights of any party;

(3) the arbitrators exceeded their powers;

(4) the arbitrators refused to postpone the hearing upon sufficient cause being shown therefor or refused to hear evidence material to the controversy or conducted the hearing, contrary to the provisions of Section 5 of this Act, as to prejudice substantially the rights of a party; or

(5) the arbitrators committed an error of law other than alleged errors relating to the admissibility of evidence.

Sec. ___. GOVERNING LAW. In an arbitration proceeding under this Act, the provisions of this Act shall govern if a conflict arises between this Act and any other law. Except to the extent as modified proceedings under this Act shall be governed by the Texas General Arbitration Act.

Sec. _____. REPORTING TO STATE BOARDS. The association or administrative judge shall transmit to the applicable licensing board of any respondent party a copy of the demand for arbitration within 10 days of filing. The agencies shall receive a copy of the decision of the panel within 10 days of filing. The reports shall be filed for informational purposes and the making or filing of a report shall not of itself be a ground for discipline.

Sec. ____. DESIGNATION OF DISTRICT. For the purposes of this Act only, Rockwall County shall be considered a part of the First Administrative Judicial District.

The amendment to the pending amendment was read.

On motion of Senator Adams, the amendment to the pending amendment was tabled by the following vote: Yeas 16, Nays 12, Paired Vote 1.

Yeas: Adams, Aikin, Braecklein, Brooks, Clower, Doggett, Jones of Harris, Kothmann, Longoria, Mauzy, Ogg, Parker, Schwartz, Snelson, Truan, Williams.

Nays: Andujar, Creighton, Farabee, Harris, Jones of Taylor, Lombardino, Meier, Mengden, Patman, Santiesteban, Sherman, Traeger.

Absent: Moore.

Absent-excused: McKnight.

PAIRED VOTE

Senator Hance (present), who would vote "Nay", with Senator McKnight (absent), who would vote "Yea".

Senator Hance offered the following amendment to the pending amendment:

Amend Amendment No. 1 to **C.S.H.B. 1048** by striking all of Subchapter D, Section 4.01, and substituting in lieu thereof the following to read:

"Section 4.01. NOTICE. (a) Any person or his authorized agent asserting a health care liability claim shall give written notice of such claim by certified mail, return receipt requested, to each physician or health care provider against whom such claim is being made at least 60 days before the earliest of the following events. The filing of a suit in any court of this state based upon a health care liability claim.

"(b) In a petition, demand or request filed with or for a court proceeding, the claimant shall state that notice has been given to the physician or health care provider as provided in this Act and shall provide such evidence of the notice as the judge of the court may require to determine if the provisions of this Act have been met.

"(c) Notice given as provided in this Act shall toll the applicable statute of limitations to and including a period of 60 days following the giving of the notice, and this tolling shall apply to all parties and potential parties."

The amendment to the pending amendment was read.

Senator Schwartz offered the following substitute for the amendment to the pending amendment:

Amend Amendment No. 1 to **C.S.H.B. 1048** by striking all of Subchapter D.

The substitute for the amendment to the pending amendment was read.

On motion of Senator Hance the substitute for the amendment to the pending amendment was tabled by the following vote: Yeas 25, Nays 5.

Yeas: Adams, Aikin, Andujar, Braecklein, Brooks, Creighton, Doggett, Farabee, Hance, Harris, Jones of Taylor, Kothmann, Lombardino, Longoria, Meier, Mengden, Moore, Ogg, Parker, Patman, Santiesteban, Snelson, Traeger, Truan, Williams.

Nays: Clower, Jones of Harris, Mauzy, Schwartz, Sherman.

Absent-excused: McKnight.

The amendment to the pending amendment was then adopted.

SENATOR ANNOUNCED PRESENT

Senator McKnight who had previously been recorded as "Absent-Excused" was announced "Present".

Senator Meier offered the following amendment to the pending amendment:

Amend Amendment No. 1 to the Committee Substitute for **H.B. 1048** by adding to Part 1 thereof a new subchapter. Said new subchapter to be added on page 35 after the existing Subchapter M in said amendment and bill. Said new subchapter to be appropriately numbered and the balance of said Part 1 in said amendment and bill to be renumbered accordingly. Said new subchapter to read as follows:

"SUBCHAPTER ____. STANDARD OF CARE

"Section ___. STANDARD OF CARE FOR HEALTH CARE LIABILITY CLAIMS. (a) Insofar as any health care liability claim is based on any alleged negligence on the part of any physician or health care provider, no recovery thereon shall be allowed unless such physician or health care provider commits one or more acts or omission of medical or health care negligence defined as follows:

"(1) Medical or health care negligence means failure to use that degree of care, whether by act or omission, which would ordinarily be used by reasonable physicians or health care providers of like kind in the same or a similar community under the same or similar circumstances.

"(2) The following shall be added to the above definition when applicable: Selection of a particular method of rendition of medical care from among alternative methods which are recognized by at least a respectable minority of reasonable physicians or health care providers of like kind in the same or a similar community under the same or similar circumstances does not constitute medical or health care negligence.

"(3) It is not necessarily negligent, within the meaning of the above definition, for either or the following to occur, nor does either of the following of itself constitute medical or health care negligence: (a) An unsatisfactory medical or health care result; or (b) an honest error or mistake in professional judgment.

"(4) In all jury trials of health care liability claims in any court in this State the trial judge shall include in the charge to the jury the foregoing definition of medical or health care negligence as set forth in Subsections (a)(1) and (a)(3) and when applicable, Subsection (a)(2); provided, however, that if the trial court, in its discretion, determines that this definition should be modified to apply to extraordinary circumstances of the particular case, then the trial court shall make appropriate modifications with respect to this definition.

"(b) Nothing herein shall abrogate any right of recovery against a physician or health care provider on any theory other than medical or health care negligence, such as battery or gross negligence."

The amendment to the pending amendment was read.

Senator Schwartz moved to table the amendment to the pending amendment.

The motion to table was lost by the following vote: Yeas 12, Nays 19.

Yeas: Braecklein, Brooks, Clower, Hance, Jones of Harris, Kothmann, Mauzy, Ogg, Parker, Patman, Schwartz, Truan.

Nays: Adams, Aikin, Andujar, Creighton, Doggett, Farabee, Harris, Jones of Taylor, Lombardino, Longoria, McKnight, Meier, Mengden, Moore, Santiesteban, Sherman, Snelson, Traeger, Williams.

The amendment to the pending amendment was then adopted.

RECORD OF VOTE

Senator Mauzy asked to be recorded as voting "Nay" on the adoption of the amendment to the pending amendment.

Senator Adams offered the following amendment to the pending amendment:

Amend Amendment No. 1 to the Committee Substitute for **H.B. 1048** so as to strike all of Section 9.05 of Subchapter I (Bad Faith Cause of Action) therefrom.

The amendment to the pending amendment was read and was adopted.

Senator Adams offered the following amendment to the pending amendment:

Amend Amendment No. 1 to the Committee Substitute for **H.B. 1048** so as to strike all of Sections 9.01 through 9.05 of Subchapter I (Bad Faith Cause of Action) therefrom, and renumbering subsequent sections thereof accordingly.

The amendment to the pending amendment was read and failed of adoption by the following vote: Yeas 15, Nays 16.

Yeas: Adams, Aikin, Braecklein, Clower, Doggett, Hance, Jones of Harris, Kothmann, Mauzy, McKnight, Meier, Ogg, Santiesteban, Schwartz, Truan.

Nays: Andujar, Brooks, Creighton, Farabee, Harris, Jones of Taylor, Lombardino, Longoria, Mengden, Moore, Parker, Patman, Sherman, Snelson, Traeger, Williams.

Senator Farabee offered the following amendment to the pending amendment:

Amend Amendment No. 1 to the Committee Substitute for **H.B. 1048** by adding after Section 21.02 under Part 2 of said amendment and bill a new section to be appropriately numbered. Said new section to read as follows:

"Sec. 21.03. EMERGENCY MEDICAL CARE: RELIEF FROM LIABILITY FOR CIVIL DAMAGES UNDER CERTAIN CIRCUMSTANCES. (a) As used in this section 'emergency' medical care means such as is rendered to a person who is unconscious, ill or injured, when the reasonable apparent circumstances require prompt decisions and actions in medical care, and when the necessity of immediate medical care is so reasonably apparent that any delay in the rendering of the care or treatment would seriously worsen the physical condition or endanger the life of the person, regardless of the location of same.

"(b) If any physician renders emergency medical care to a person who is not at the time thereof a patient of such physician, and if such physician does not subsequently bill such person for such emergency medical care, then such physician shall not be liable for damages for injuries alleged to have been sustained by the person or for damages for the death of the person alleged to have occurred by reason

of any act or omission in the rendering of such emergency medical care, unless it is established that the injuries were or the death was caused by gross negligence, wanton conduct or intentional wrongdoing on the part of the physician rendering such emergency medical care.

"(c) Nothing in this section shall be deemed or construed to relieve any person from liability for damages or injury or death caused by an act or omission on the part of such person while rendering medical care services in the normal and ordinary course of one's profession."

The amendment to the pending amendment was read and adopted.

RECORD OF VOTE

Senator Ogg asked to be recorded as voting "Nay" on the adoption of the amendment to the pending amendment.

Senator Jones of Harris offered the following amendment to the pending amendment:

Amend Floor Amendment No. 1 to **C.S.H.B. 1048**, by striking subsection (e) of Section 22.13 and substitute the following:

"(e) The trust established herein is deemed to be engaged in the business of insurance under this code and the laws of this state and the provisions of this code relative to the transaction of fire and casualty insurance, including but not limited to capitalization, rate filing, policy issuance, investments and guaranty fund protection are declared applicable to trusts organized under this article. Further, it is provided that a trust created under the provisions of this article shall not operate or issue or cause to be issued any policy of insurance where such limits of coverage is being provided by two or more insurers as that term is defined by Article 5.15-1, Section 2, Subsection 3."

The amendment to the pending amendment was read.

On motion of Senator Farabee the amendment to the pending amendment was tabled by the following vote: Yeas 20, Nays 11.

Yeas: Adams, Aikin, Andujar, Braecklein, Brooks, Creighton, Farabee, Harris, Jones of Taylor, Lombardino, McKnight, Mengden, Moore, Patman, Santiesteban, Schwartz, Sherman, Snelson, Traeger, Williams.

Nays: Clower, Doggett, Hance, Jones of Harris, Kothmann, Longoria, Mauzy, Meier, Ogg, Parker, Truan.

Senator Farabee offered the following amendment to the pending amendment:

Amend Amendment No. 1 by striking subsection (b) to Section 22.13, and substituting in lieu thereof the following:

"(b) An incorporated association, the purpose of which, among other things, shall be to federate and bring into one compact organization the entire profession licensed to practice medicine and surgery in the State of Texas and to unite with similar associations of other other states to form a nation-wide medical association, may create a trust to self-insure physicians and by contract or otherwise agree to

insure other members of the organization or association against health care liability claims and related risks on complying with the following conditions:

"(1) the organization or association must have been in continuing existence for a period of at least two years prior to the effective date of this Act;

"(2) establishment of a health care liability claim trust or other agreement to provide coverage against health care liability claims and related risks; and

"(3) employment of appropriate professional staff and consultants for program management."

The amendment to the pending amendment was read and was adopted.

RECORD OF VOTES

Senators Mauzy, Truan, Doggett, Williams and Ogg asked to be recorded as voting "Nay" on the adoption of the amendment to the pending amendment.

Senator Doggett offered the following amendment to the pending amendment:

Amend Amendment No. 1 to **H.B. 1048**, Section 22.05, page 20 by striking lines 2-9 and substituting the following in lieu thereof:

"exceeding a total of $1 million per occurrence and $2 million aggregate per annum."

The amendment to the pending amendment was read.

Senator Jones of Taylor offered the following substitute for the amendment to the pending amendment.

Amend Subsection (b)(1) of quoted Section 3, Article 21.49-3, Insurance Code in Section 22.05 of **H.B. 1048** by deleting the language following the word "exceeding" and substituting in lieu thereof the following: "a total of $750,000 per occurrence and $1,500,000 aggregate per annum."

The substitute for the amendment to the pending amendment was read.

Senator Doggett moved to table the substitute for the amendment to the pending amendment.

The motion to table was lost by the following vote: Yeas 11, Nays 20.

Yeas: Aikin, Clower, Doggett, Jones of Harris, Kothmann, Mauzy, Ogg, Schwartz, Sherman, Snelson, Truan.

Nays: Adams, Andujar, Braecklein, Brooks, Creighton, Farabee, Hance, Harris, Jones of Taylor, Lombardino, Longoria, McKnight, Meier, Mengden, Moore, Parker, Patman, Santiesteban, Traeger, Williams.

The substitute for the amendment to the pending amendment was then adopted.

RECORD OF VOTES

Senators Mauzy and Ogg asked to be recorded as voting "Nay" on the adoption of the substitute for the amendment to the pending amendment.

The amendment to the pending amendment as substituted was then adopted.

RECORD OF VOTES

Senators Mauzy and Ogg asked to be recorded as voting "Nay" on the adoption of the amendment to the pending amendment as substituted.

VOTE BY WHICH AMENDMENT FAILED OF ADOPTION RECONSIDERED

Senator Brooks moved to reconsider the vote by which Senator Adams' amendment (striking Sections 9.01 through 9.05 of Subchapter I) failed of adoption, he having voted on the prevailing side.

The motion prevailed by the following vote: Yeas 17, Nays 14.

Yeas: Adams, Aikin, Braecklein, Brooks, Clower, Doggett, Hance, Jones of Harris, Kothmann, Longoria, Mauzy, McKnight, Meier, Ogg, Santiesteban, Schwartz, Truan.

Nays: Andujar, Creighton, Farabee, Harris, Jones of Taylor, Lombardino, Mengden, Moore, Parker, Patman, Sherman, Snelson, Traeger, Williams.

Question - Shall the amendment be adopted?

The amendment was adopted.

The pending amendment as amended was then adopted.

RECORD OF VOTES

Senators Schwartz, Mauzy, and Ogg asked to be recorded as voting "Nay" on the adoption of the pending amendment as amended.

On motion of Senator Schwartz and by unanimous consent, the caption was amended to conform to the body of the bill as amended.

The bill as amended was passed to third reading by the following vote: Yeas 28, Nays 3.

Yeas: Adams, Aikin, Andujar, Braecklein, Brooks, Clower, Creighton, Doggett, Farabee, Hance, Harris, Jones of Taylor, Kothmann, Lombardino, Longoria, McKnight, Meier, Mengden, Moore, Ogg, Parker, Patman, Santiesteban, Sherman, Snelson, Traeger, Truan, Williams.

Nays: Jones of Harris, Mauzy, Schwartz.

MOTION TO PLACE COMMITTEE SUBSTITUTE HOUSE BILL 1048 ON THIRD READING

Senator Farabee moved that the Constitutional Rule and Senate Rule 68 requiring bills to be read on three several days be suspended and that **C.S.H.B. 1048** be placed on its third reading and final passage.

On motion of Senator Farabee and by unanimous consent, the motion to suspend the rules to place **C.S.H.B. 1048** on its third reading was withdrawn.

COMMITTEE SUBSTITUTE HOUSE BILL 1048 SET AS SPECIAL ORDER

Senator Farabee moved that **C.S.H.B. 1048** be set as a Special Order at the conclusion of Morning Call on Tuesday, April 19, 1977.

The motion prevailed by the following vote: Yeas 21, Nays 10.

Yeas: Adams, Aikin, Andujar, Braecklein, Brooks, Creighton, Farabee, Hance, Harris, Jones of Taylor, Lombardino, Longoria, McKnight, Meier, Mengden, Moore, Patman, Santiesteban, Snelson, Traeger, Williams.

Nays: Clower, Doggett, Jones of Harris, Kothmann, Mauzy, Ogg, Parker, Schwartz, Sherman, Truan.

BILLS SIGNED

The President announced the signing in the presence of the Senate after the caption had been read, the following enrolled bills:

H.B. 280
H.B. 298
H.B. 685

MESSAGE FROM THE HOUSE

House Chamber
April 18, 1977

Honorable William P. Hobby
President of the Senate

Sir: I am directed by the House to inform the Senate that the House has passed the following:

All necessary rules suspended, and the Conference Committee Report on House Bill No. 502 adopted by a vote of 125 Ayes, 7 Noes, 6 Present-Not Voting.

Respectfully submitted,
BETTY MURRAY, Chief Clerk
House of Representatives

MEMORIAL RESOLUTIONS

S.R. 524 - by Snelson: Memorial resolution for Floyd Elbert (Shorty) Parker.

S.R. 525 - by Snelson: Memorial resolution for Rev. Edward Bernard Postert, O.M.I.

WELCOME AND CONGRATULATORY RESOLUTIONS

S.R. 521 - by Doggett: Extending welcome to Reverend Carl Siegenthaler.

S.R. 522 - by Adams: Extending congratulations to Henderson County honorees of the Family Land Heritage Program.

S.R. 523 - by Clower: Extending welcome to Australian Trade Commissioner-Deputy Consul-General Michael G. B. Coultas.

S.R. 526 - by Snelson: Extending congratulations to Mrs. Joe Mims.

S.R. 527 - by Clower: Extending welcome to Green McCurtain.

S.R. 528 - by Clower: Extending welcome to Ray Johnson.

S.R. 529 - by Clower: Extending welcome to Mrs. Art Keeney, Mrs. Ed Jezek, Mrs. Rufus Shell, and Gene R. Barron.

S.R. 530 - by Clower: Extending welcome to Carmen Anico.

S.R. 531 - by Clower: Extending welcome to Jim Brown.

S.R. 532 - by Clower: Extending welcome to Tribal Chief Raul Garza.

S.R. 533 - by Clower: Extending welcome to War Chief George Whitewater.

ADJOURNMENT

On motion of Senator Aikin the Senate at 7:21 o'clock p.m. adjourned until 10:30 o'clock a.m. tomorrow.

FIFTY-THIRD DAY
(Tuesday, April 19, 1977)

The Senate met at 10:30 o'clock a.m., pursuant to adjournment, and was called to order by the President.

The roll was called and the following Senators were present: Adams, Aikin, Andujar, Braecklein, Brooks, Clower, Creighton, Doggett, Farabee, Hance, Harris, Jones of Harris, Jones of Taylor, Kothmann, Lombardino, Longoria, Mauzy, McKnight, Meier, Mengden, Moore, Ogg, Parker, Patman, Santiesteban, Schwartz, Sherman, Snelson, Traeger, Truan, Williams.

A quorum was announced present.

The Reverend Dr. Edwin T. Salvant, Jr., Pastor, Wilshire Presbyterian Church, Austin, Texas, offered the invocation as follows: